My group benefit plan

canada life™

Archdiocese of Vancouver

Ordained Priests

BENEFIT DETAILS

Canada Life is a leading Canadian life and health insurer. Canada Life's financial security advisors work with our clients from coast to coast to help them secure their financial future. We provide a wide range of retirement savings and income plans; as well as life, disability and critical illness insurance for individuals and families. As a leading provider of employee benefits in Canada, we offer effective benefit solutions for large and small employee groups.

Canada Life Online

Visit our website at www.canadalife.com for:

- information and details on Canada Life's corporate profile and our products and services
- investor information
- news releases
- contact information
- online claims submission

My Canada Life at Work

As a Canada Life plan member, you can register for My Canada Life at Work™ at www.mycanadalifeatwork.com. Make sure to have your plan and ID numbers available when registering.

With My Canada Life at Work you can:

- Submit claims quickly
- Review your coverage and balances
- Find healthcare providers like chiropractors and massage therapists near you
- Save your benefits cards to your payment service application or program
- Get notified when your claims have been processed

Canada Life's Toll-Free Number

- For assistance with your medical and dental coverage, please call 1-800-957-9777
- For all other inquiries, please call 1-888-252-1847

Process to make a complaint

If you have any concerns regarding these products or Canada Life's services, please let us know. You can call:

Toll-free: 1-888-252-1847

You can also contact Canada Life on our website by visiting www.canadalife.com/complaints.

The information provided in the booklet is intended to summarize the provisions of Group Policy Nos. 335645 and 335646 and Plan Document No. 56565 and Group Policy Nos. 100007814 , 100005769 and 100007862 issued to your employer by Industrial Alliance Insurance and Financial Services Inc.. If there are variations between the information in the booklet and the provisions of the policies or plan document, the policies or plan document will prevail to the extent permitted by law.

This booklet contains important information and should be kept in a safe place known to you and your family.

The Plan is administered by

and

Industrial Alliance Insurance and Financial Services Inc.

This booklet was prepared on: May 14, 2026

Access to Documents

You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided to Canada Life as evidence of insurability, subject to certain limitations.

Legal Actions

Insured benefits

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* (for actions or proceedings governed by the laws of Alberta and British Columbia), *The Insurance Act* (for actions or proceedings governed by the laws of Manitoba), the *Limitations Act, 2002* (for actions or proceedings governed by the laws of Ontario), or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

Non-insured benefits

No legal action to recover non-insured benefits under this plan can be introduced for 60 days after notice of claim is submitted, or more than two years after a benefit has been denied.

Appeals

Insured benefits

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Non-insured benefits

You have the right to appeal a denial of all or part of the coverage or benefits described in this plan as long as you do so within two years after the denial. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit Limitation for Overpayment

Insured benefits

If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days after Canada Life sends you a notice of the overpayment, or within a longer period if agreed to in writing by Canada Life. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit Canada Life's right to use other legal means to recover the overpayment.

Non-insured benefits

If benefits are overpaid you are responsible for repayment within six months, or within a longer period if agreed to by your employer. If you fail to fulfill this responsibility, further benefits will be withheld until the overpayment is recovered. This does not limit your employer's right to use other legal means to recover the overpayment.

Quebec Time Limit for the Payment of Benefits

Where Quebec law applies, benefits will be paid in accordance with the terms of the plan within the following time period:

- for death benefits, 30 days following receipt of the required proof of claim.
- for disability income benefits for which there is no waiting period, 30 days following receipt of the required proof of claim.
- for disability income benefits for which there is a waiting period, 30 days from the expiry of the waiting period provided the required proof of claim has been received.
- for any other benefit, 60 days following receipt of the required proof of claim.

Employer Role

For insured benefits, the employer's role is limited to providing employees with information and not advice.

Privacy

Protecting Your Personal Information. At Canada Life, we're committed to protecting personal information and respecting your privacy. Personal information is information that either on its own or combined with other information allows an individual to be identified. This includes your name and address, as well as more sensitive information such as your health and financial records. When applicable, this includes information about other people such as your spouse, common-law partner, and children.

How we use your personal information. Your personal information is used to provide you with products and services and to improve our business operations. This includes verifying your identity, maintaining your profile, and informing you about features of the products you already have with us. It's also used to provide you with advice, evaluate your eligibility for products, price our products, collect feedback on our customer service, process claims and other financial transactions, protect you and us from risks such as cyber threats and fraud, and comply with legal obligations. If you provided your social insurance number (SIN), we'll use it for tax reporting. Your SIN is also used to link your products together and to keep your information separate from other customers with similar names.

Who we share personal information with. We share your personal information with other people and organizations who help us administer your products and provide you with services. This may include your advisor or people who work with your advisor, our Canadian subsidiaries, and other organizations that provide us services such as paramedical examiners, medical laboratories, MIB, LLC., specialty coverage providers, independent medical examiners, and pharmacy benefits managers. As well, we may share your information with claims assessors, travel assistance providers, technology suppliers, other insurance or reinsurance companies, other financial institutions, and credit reporting agencies. As part of our day-to-day business, your personal information may be communicated to government departments and agencies, and may be communicated outside your province of residence or outside Canada. We take protecting your personal information seriously and we'll never sell your personal information to anyone.

You're in control of your personal information. We respect your privacy preferences and follow them when using your personal information. At any point in your relationship with us, you can choose how your personal information is used by updating your privacy preferences through your online account or by submitting a request through our privacy centre at www.canadalife.com/privacy. This includes choosing whether you receive customer experience surveys, the use of your SIN for non-tax reporting purposes, and whether and how you want to receive information and offers from Canada Life using the personal information we collect from you throughout your relationship with us. You can also exercise other privacy rights through our privacy centre such as access to or correction of your personal information.

If you choose to remove your consent to the collection, use and disclosure of the personal information required to serve you and meet our legal obligations, we may not be able to continue to provide you with products and services.

Want to learn more? Please visit www.canadalife.com/privacy.

Notice of Liability for Benefits

Your employer has entered into an agreement with The Canada Life Assurance Company whereby the Dental benefits outlined in this booklet are uninsured and your employer has liability for them.

This means that the Dental benefits are:

- an unsecured financial obligation and are payable from your employer's net income, retained earnings or other financial resources; and
- not underwritten by a licensed insurer or regulated insurer.

All claims will, however, be processed by Canada Life.

If British Columbia law applies, the giving of this notice exempts your employer from the requirements under the *British Columbia Financial Institutions Act*.

If Quebec law applies, any uninsured benefit is not under the supervision and control of the Autorité des marchés financiers.

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Welcome to Canada Life!

Welcome to Canada Life! Your employer and Canada Life have worked together to develop a package of benefits to meet your needs. These benefits are an important part of the total compensation package from your employer.

Our goal is to make it easy for you and your family to have your questions answered. If you have any questions about your benefits, you can ask your employer or contact a customer service representative.

Why is this booklet important

This booklet outlines the benefits that are available under your employer's policy with Canada Life. The section called "General Terms" includes facts about eligibility and enrolment. This is followed by a section on each of your benefits, containing benefit descriptions and the coverage that each benefit provides and what you are not covered for.

Definitions

Here are definitions for some of the terms in your employee booklet. You will find more definitions included in each section.

Actively at work

You are actively at work if you are carrying out your normal duties at:

- your employer's place of business; or
- some other location required by your employer's business.

You will also be considered actively at work if you are absent only due to a scheduled day off or vacation but otherwise able to carry out your normal duties.

Covered person

Covered person means a person who is covered under the plan.

Earnings

Earnings means your gross annual salary before any deductions, but does not include other compensation such as commissions, bonuses, dividends, overtime, profit sharing or car allowances.

Weekly earnings are annual earnings divided by 52.

Monthly earnings are annual earnings divided by 12.

Emergency

An emergency means any sudden, unexpected illness or injury for which the insured person needs immediate treatment.

Employee

Employee means an employee who has met the eligibility requirements as set forth and managed by the policyholder

A person who attains age 64 and 183 days may not become insured under the Long Term Disability benefit under this policy.

Illness

Illness means a sickness or disease of the mind or body, including conditions related to pregnancy.

Insured person

Insured person means a person who is covered under the policy.

Reasonable Treatment

Reasonable treatment means treatment that is considered reasonable if it is accepted by the Canadian medical profession, it is proven to be effective, and it is a form, intensity, frequency and duration essential to diagnosis or management of an illness, injury or pregnancy.

Waiting period for coverage

The waiting period for coverage is the time you must wait before coverage may begin.

Waiting periods for disability payments

The Short Term Disability waiting period is the time you must be absent from work due to disability before Short Term Disability payments may be made. Please refer to the "Short Term Disability coverage" section for details.

The Long Term Disability waiting period is the time you must be absent from work due to disability before Long Term Disability payments may be made. Please refer to the "Long Term Disability coverage" section for details.

We, our and us

We, our and us mean The Canada Life Assurance Company.

General Terms

Waiting period for coverage

There is no waiting period for coverage.

When your coverage begins

You must enrol to receive coverage. Your employer can provide you with the form to complete. This form must be signed and dated.

When you enrol

If you are not actively at work

If you are not actively at work on the date coverage would begin according to the following, your coverage will begin when you are actively at work.

If you enrol before the end of the waiting period for coverage

Coverage will begin on the day after the waiting period for coverage ends, if you are actively at work on that day.

If you enrol after the end of the waiting period for coverage

If you enrol within 31 days of the end of the waiting period for coverage, coverage will begin on the day after the waiting period for coverage ends, if you are actively at work on that day.

Evidence of good health is required if you enrol more than 31 days after the end of the waiting period for coverage. Coverage will begin on the date the evidence of good health is approved by us, if you are actively at work on that day.

What changes to report to your employer

You must report the following changes immediately to your employer:

- change to your coverage;
- change of name;
- change of beneficiary, or
- change of banking information (if we are depositing your claim expenses directly into your bank account).

You report these changes by filling out the appropriate form that is available from your employer. You must sign and date all forms.

Any resulting change in your coverage will take effect on the date the above changes occur. You must be actively working for any increase in coverage to take effect.

When your coverage ends

This section applies to all benefits. Any additional terms that apply to a particular benefit have been included in that benefit section.

Your coverage ends

Your coverage will end on the earliest of the following dates:

- the date you no longer satisfy the definition of employee;
- the date you become a full-time member of the armed forces.

If you are absent from work due to a temporary lay-off, coverage may be continued until the last day of the month in which the lay-off began, unless the temporary lay-off is due to the end of the school year, in which case coverage will continue until the beginning of the following school year.

Beneficiary designation

You may make, alter or revoke a designation of beneficiary as permitted by law. Any designation of beneficiary you made under your employer's previous policy prior to the effective date of this policy applies to this policy until you make a change to that designation. You should review your beneficiary designation made under this policy from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your employer.

Medical examinations and autopsies

When you apply for coverage, we may ask for a medical examination by a physician of our choice, depending on the medical condition or the amount of coverage applied for. We will pay for this examination.

You will have to pay for this examination if the application is completed more than 31 days after the end of the waiting period for coverage.

When you submit a claim for payment, we may ask the covered person to have medical examinations by physicians of our choice. We will pay for these examinations. We will not make any claim payments if the covered person refuses to have these examinations.

If a death occurs, we can ask for an autopsy to be performed. We will pay for the autopsy.

Recovering damages from a third party

If another person or organization is responsible for causing a disability or a medical or dental condition, we will suspend payments and recover our payments from the amount you recover for loss of income or the medical or dental condition through legal action or an out-of-court settlement as we are entitled in law to do. We also reserve the right to recover our payments directly from the person or organization that caused the disability or condition. You shall co-operate with us in our attempt to recover our payments, including participation in a lawsuit. You must notify us of any planned legal action and when payments are received.

Incontestability

If a loss or disability occurs within the first two years of coverage or increased coverage, we will void coverage retroactive to the effective date of coverage or increased coverage, if the covered person made any false statements or withheld any information on the enrolment form, evidence of good health form or in any written statement.

If a loss or disability occurs two or more years after coverage begins or increases, we will void coverage retroactive to the effective date of coverage or increased coverage, if the covered person fraudulently either made any false statements or withheld any information on the enrolment form, evidence of good health form or in any written statement.

We can end coverage at any time if the covered person made any false statement about age.

Your Health Care coverage

What is Your Health Care coverage

We will pay for the usual cost of covered services and supplies that are medically necessary to treat an illness, injury or pregnancy.

We will only cover:

- The amount that is usually charged for the service or supplies in the area in which the charge is made.
- Services and supplies that are needed to diagnose or treat an illness, injury or pregnancy and that are recognized by the Canadian Medical Association as effective and appropriate and based on accepted standards of Canadian health care.
- Services and supplies that we are legally allowed by the government to cover. We will not cover any portion of services or supplies which the insured person is entitled to receive, or for which the insured person is entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government ("government plan"), without regard to whether coverage would have otherwise been available under this plan. In this limitation, government plan does not include a group plan for government employees.
- Charges for services and supplies that are incurred while the person is insured.

The coverage includes the following. Details of coverage can be found under "What you are covered for":

- Drugs
- Hospital accommodation
- Laser eye surgery, eye examinations, eyeglasses or contact lenses
- Medical services and equipment
- Paramedical services
- Referrals for medical treatment outside the insured person's home province
- Emergency out-of-province/country treatment

How much we will pay

We will pay a percentage of the covered medical costs, up to any maximum amounts stated in the description of the benefit. Before we pay a benefit under this coverage, you must pay the deductible amount if any.

The deductible is $25, each calendar year, unless otherwise shown below.

The following is an overview of what we will pay. Please see the "What you are covered for" section for specific details.

For covered drugs purchased in Quebec, 80% of the covered costs after the deductible is paid.

For covered drugs purchased outside Quebec:

- covered drugs purchased from Costco Wholesale Canada Ltd. or one of its affiliates using the drug card, 90% of the covered costs after the deductible is paid.
- covered drugs subject to Prior Authorization or Health Case Management and purchased from a provider designated by us (whether or not the insured person used the drug card), 90% of the covered costs after the deductible is paid.
- covered drugs purchased from another source or covered drugs purchased without the drug card, 80% of the covered costs after the deductible is paid.

For hospital expenses, 80% of the difference between the cost of a ward and a semi-private room in a hospital after the deductible is paid.

For laser eye surgery, eyeglasses and contact lenses, 80% of the covered costs up to $300 and $65 for eye examinations in any two consecutive calendar year period for an insured person age 21 and over and every calendar year for an insured person under age 21 after the deductible is paid.

For emergency out-of-province/country, 100% of the covered costs above the insured person's provincial health plan coverage with no deductible.

For all other expenses, 80% of the covered costs after the deductible is paid.

When your Health Care coverage ends

Please see "When your coverage ends" in the “General Terms” section for additional terms that apply to when your coverage ends.

If the insured person is totally disabled when your employment ends

Coverage will be continued for you if you are totally disabled on the date it would otherwise end because you are no longer employed. We will continue to pay covered costs that result from the total disability for 90 days, while the policy is in force.

For Health Care coverage, you are totally disabled while unable to perform the essential duties of any occupation for which you are reasonably suited by education, training or experience, for any employer.

What you are covered for

Drugs

We cover the cost of drugs that can only be obtained with a prescription and are prescribed by a person entitled by law to prescribe them and dispensed by a person entitled by law to dispense them. We will only pay for eligible drugs that are approved by the Canadian government for sale to the general public and that have a Drug Identification Number (DIN). This does not include experimental drugs. We also cover some life-supporting, non-prescription drugs approved by us as well as disposable needles, syringes, lancets, testing materials and sensors for flash glucose monitoring machines for monitoring diabetes.

We cover up to a 100 day supply for all drugs.

An insured person can use the drug card to purchase eligible drugs. Use of the drug card authorizes us, or our authorized agent, to inform pharmacists and physicians on patient safety issues for the insured person. We, or our authorized agent, are not legally liable for this information.

An insured person may not be able to use the drug card to buy drugs from a physician, dentist, clinic, hospital, or some pharmacies, but you can make a claim for the cost of eligible medicines by using a claim form and including the receipts. A receipt must show the prescription number and the name of the drug or Drug Identification Number (DIN).

We will not pay for the following:

- alcohol
- bandages
- contraception, other than contraceptive drugs and products containing a contraceptive drug which are *not* used for contraception
- drugs used as abortifacients
- cosmetic items
- hair growth stimulants
- sunscreens
- cotton
- vitamins (except injectible), minerals, dietary supplements
- food substitutes, infant food or formula
- disinfectants

- homeopathic medicines
- immunizations and vaccines
- non-disposable insulin injectors
- products used to quit smoking
- spring loaded devices used to hold lancets
- products used to lose weight
- drugs or drug supplies that appear on an exclusion list maintained by Canada Life. Canada Life may exclude coverage for all covered expenses for a drug or drug supply, or only those covered expenses that relate to the treatment of specific diseases or injuries or the stages or progressions of specific diseases or injuries. Canada Life may add or remove a drug or drug supply from an exclusion list at any time.

  For greater certainty, a drug or drug supply may be added to an exclusion list for any reason including, but not limited to, the following:

  - Canada Life determining that further information from professional advisory bodies, government agencies or the manufacturer of the drug or drug supply is necessary to assess the drug or drug supply; or
  - Canada Life determining that the drug or drug supply is not proportionate to the disease or injury or, where applicable, the stage or progression of the disease or injury.

Hospital accommodation

We will cover the difference between the cost of a ward and a semi-private room in a hospital. Room charges for outpatients will not be covered. The hospital stay must be because of illness, injury or pregnancy.

A hospital is a facility that is licensed to provide active, convalescent or chronic care treatment for sick or injured patients. It does not include nursing homes, homes for the aged, rest homes or any other facility that provides similar care.

Laser eye surgery, eye examinations, eyeglasses or contact lenses

We will cover the cost of laser eye surgery, contact lenses or eyeglasses, including sunglasses or safety glasses, prescribed by an ophthalmologist or optometrist, if they are prescribed to correct vision. We will pay up to the maximum amount shown in the "How much we will pay" section.

We will cover the cost of one eye examination (including eye refractions)

- every calendar year for an insured person under age 21, or
- every two calendar years for an insured person age 21 or over.

We will pay 50% of the cost of:

- visual training
- remedial exercises.

When you make a claim, make sure that the receipt includes the name of the person who was prescribed the eyeglasses or contact lenses, as well as the date on which they were received. Receipts for deposits are not acceptable. If you have a receipt for a deposit, send it along with the receipt for the balance when you make a claim.

Medical services and equipment

We will cover the cost of the following services and supplies if they are prescribed by a physician:

- services provided by a professional nurse. We must approve the services before we will cover the cost. These services must be provided in the insured person's home by a professional nurse who does not normally live with, is not related to, nor is a member of the insured person's immediate family.

  We will pay up to $10,000 per calendar year until the insured person reaches age 65. After age 65, we will pay up to $10,000 per calendar year with a lifetime maximum of $25,000. This change to a lifetime maximum takes place on the January 1st following the 65th birthday. If the birthday is January 1st, this $25,000 lifetime maximum begins on the 65th birthday.

  We will not cover the cost of a professional nurse if the care they provide is not the skilled duties that only they can provide. We will also not cover the cost of care from a professional nurse that is provided in a nursing home, rest home, home for the aged, hospital, or any facility that provides similar care.

  A professional nurse is a Registered Nurse or a Licensed Practical Nurse. If the insured person lives in Ontario, a professional nurse is a Registered Nurse or a Registered Practical Nurse.

- out-patient services and supplies from a hospital in the insured person's home province or from a surgical supply company.

- walkers, braces, artificial limbs and eyes, and other prosthetic devices that we approve. As the cost of these items varies greatly, we recommend that you contact us before purchasing a device. We will ask you for the written information that we require to determine how much of the cost we will cover based on the least expensive device that is medically adequate and, once it is provided, we will advise you of the amount we will cover.

- crutches and canes.

- initial pair of frames and one corrective lens, contact lens or prosthetic lens prescribed after cataract surgery and only for the eye that had the surgery. We will cover once per eye in the insured person's lifetime.

- breast prosthesis after a mastectomy, including replacement(s) every two calendar years, and two surgical bras in a calendar year.

- oxygen.

- custom-made orthopaedic shoes, prescribed by a physician, podiatrist or chiropodist, when no other method such as orthotics and/or off-the-shelf orthopaedic shoes can correct the problem. We will cover one pair each calendar year. We will not cover modifications to shoes.

- foot orthotics prescribed by a physician, podiatrist, or chiropodist, 1 pair per two calendar years. They must be determined as being necessary by a biomechanical examination and be custom-made. They must be required to carry out regular daily living activities, and not just for sports or recreation. We will pay up to $300 in any two calendar years.

- two pairs of surgical stockings each calendar year.

- wigs, up to $100 in the insured person's lifetime following chemotherapy or radiation treatment, and up to $250 in the insured person's lifetime for total hair loss from alopecia totalis, a medical condition where all of the hair is lost.

- certain diagnostic tests, radium treatments and x-rays performed in the insured person's province of residence when coverage is not available under the provincial government.

- services directly provided by a speech therapist. The speech therapist must be registered in the province where the service is given and cannot be a person who normally lives with the insured person nor be a person related to nor a member of the insured person's immediate family. We will pay up to $1,000 per insured person in a calendar year.

- services directly provided by a registered psychologist, qualified social worker, qualified psychotherapist, qualified therapist, or qualified counsellor. The registered psychologist, qualified social worker, qualified psychotherapist, qualified therapist, or qualified counsellor must be registered in the province where the service is given and cannot be a person who normally lives with the insured person nor be a person related to nor a member of the insured person's immediate family. We will pay up to a combined maximum of $1,000 per insured person in a calendar year.

- hearing aids and repairs, not including batteries. We will pay up to $500 in any period of four consecutive calendar years.

- rental charges for wheelchairs, hospital beds and other temporary therapeutic equipment that we approve. We may cover the cost of purchasing this equipment if we determine that it is more economical than renting. We must approve the purchase before it is made. We will pay for the least expensive device that is medically adequate.

The following is a list of examples of items that we will cover if prescribed by a physician and approved by us:

- aerochambers
- apnea monitor
- casts
- ostomy supplies
- compressors
- blood glucose monitor
- flash glucose monitoring machines
- continuous glucose monitoring machines, to a maximum of $4,000 per calendar year
- grab bars
- Mozes detector
- nebulizers to administer asthma medication
- oxygen equipment and
- T.E.N.S. machine (for chronic pain)

The following is a list of examples of items that we will not cover even if prescribed by a physician:

- air conditioners or purifiers
- blood pressure kits
- breast pumps
- Craftmatic, Ultramatic or other lifestyle beds
- exercise equipment, machines or programs
- home or car modifications (for example, ramps or lifts)
- humidifiers
- mattresses (except for standard mattresses with approved hospital beds)
- Obus Formes or orthopaedic pillows

Ambulance services

We will cover the cost of a licensed ambulance or other emergency service that transports the insured person to and from the nearest hospital that is able to give the necessary treatment. This covers travel between hospitals. If transportation is not provided by a licensed ambulance, we may also cover the cost of a person accompanying the insured person, if it is medically necessary.

Dental accident

If healthy, natural teeth are damaged or lost due to a sudden impact, we will cover the cost of the dental services required to repair or replace the teeth if the impact that caused the damage or loss happened while the insured person is covered under this provision. This does not include damage or loss caused by objects or food placed in the mouth.

The amount we will pay is based on the least expensive treatment that is adequate to correct the damage. We will not cover more than the fee stated in the current Dental Association General Practitioner's Fee Guide. This treatment must be completed within 12 months of the impact. If treatment is scheduled to occur more than 90 days after the impact, we must be given a treatment plan before the end of the 90-day period.

Orthodontic care must be for relocating teeth that are accidentally forced out of position or for splinting damaged teeth for stability. Dental procedures to correct existing crossbites, alignment of rotated teeth, closing of spaces, and uprighting teeth are not covered. Implants and treatment related to implants are also not covered.

Paramedical services

We will pay up to $500 in a calendar year for the services of each of the following:

- acupuncturists
- chiropodists or podiatrists
- chiropractors
- massage therapists
- naturopaths
- osteopaths
- physiotherapists, athletic therapists or occupational therapists

Costs for speech therapists and clinical psychologists are included in Health Care coverage. For details, please look under "Medical services and equipment."

We will cover up to the usual charge for each service, up to the maximum charge set in the Schedule of Fees for the type of paramedical practitioner providing the service. If there is no Schedule of Fees, we will set a fee for the service.

We will cover the cost of laboratory tests and x-rays recommended by a licensed chiropractor, osteopath or podiatrist.

Where provincial registration exists, the paramedical practitioner must be registered in the province where the service is given, and the paramedical practitioner cannot be a person who normally lives with the insured person nor be a person related to nor a member of the insured person's immediate family.

Other Services and Supplies

We can, on such terms as we determine, cover services and supplies under this plan where the service or supply represents reasonable treatment.

Referrals for treatment outside your home province

If a physician in the insured person's home province gives a written referral for treatment that is not performed in that home province, we will cover the cost of the treatment as specified below, if it is provided in Canada or the United States.

The physician must give us full details of the treatment and we must approve it in advance. The insured person must apply and provide us with a statement from the provincial health plan that describes what it will cover.

We will pay up to $10,000 in the insured person's lifetime for the following:

- hospital room and board at the ward rate
- hospital services and supplies, and
- diagnosis and treatment by physicians

Emergency out-of-province/country coverage

The insured person must be eligible for benefits under a government health plan in Canada or the government coverage replacement plan sponsored by your employer to qualify for emergency out-of-province/country coverage.

We will cover the cost of emergency treatment, described below, that is required while temporarily outside the home province, (including outside Canada) on business or vacation. We will not cover emergency treatment while travelling for health reasons. An emergency means any sudden, unexpected illness or injury which requires immediate treatment. We will pay up to $1,000,000 for each insured person for all the covered costs related to any one emergency under this emergency out-of-province/country coverage. When emergency treatment for a condition is completed, any ongoing treatment related to that condition is not covered.

If you are on an approved leave of absence, we will only cover the first 30 days of a trip, and we will pay up to $10,000 per year for each insured person. This limitation is not applicable to in-Canada emergency health care benefits.

Travelling outside Canada while pregnant: We will not cover any pregnancy related costs which are incurred outside of Canada within nine weeks of the expected delivery date. Costs associated with a child born outside Canada within nine weeks of the expected delivery date, or after the expected delivery date, are not covered.

When used under this emergency out-of-province/country section, hospital means a facility licensed to provide emergency treatment for sick or injured patients. It must have facilities for diagnosis and treatment. Physicians and registered nurses must be in attendance 24 hours a day. It does not include nursing homes, homes for the aged, rest homes, convalescent care facilities or any facility that provides similar care.

We will cover the charges for emergency treatment that are over the amount covered by the provincial health plan of the insured person's home province. This coverage includes the cost of:

- hospital room and board at the ward rate
- hospital services and supplies, and
- treatment by licensed physicians

In emergency out-of-province/country situations, other charges included under the Health Care coverage section of this policy are covered to the same extent that they would be in Canada. This includes coverage such as wheelchair rental, crutches and prescription drugs.

In the event of a medical emergency, you or someone acting on your behalf must contact the Travel Assistance Centre prior to seeking medical treatment. If it is not reasonably possible for you to contact the Travel Assistance Centre prior to seeking medical treatment due to the nature of the medical emergency, you must contact the Travel Assistance Centre as soon as possible. Failure to contact the Travel Assistance Centre as described will result in a reduction of benefits in the case of hospitalization of 40% of eligible costs. All costs for such emergency will be limited to your emergency out-of-province/country coverage maximum or $25,000, whichever is less.

If a physician or the Travel Assistance provider recommends you to be moved to a different facility at the destination, and you choose not to go, eligible costs for emergency coverage will in the case of hospitalization be reduced by 40% of eligible costs. All costs for such emergency will be limited to your emergency out-of-province/country coverage maximum or $25,000, whichever is less.

If a physician or the Travel Assistance provider recommends you return to your home province, and you choose not to go, emergency coverage will end.

What is not covered for Emergency out-of-province/country treatment

We will not pay for any costs resulting directly or indirectly:

(a) from an accident occurring while you were operating a vehicle, vessel or aircraft, if you:
    i) were impaired by drugs or alcohol, or
    ii) had a blood alcohol level higher than 80 milligrams of alcohol per 100 millilitres of blood.
(b) from the abuse of illegal substances.

Please see "What you are not covered for under any Health Care coverage" section for additional terms that apply to emergency out-of-province/country and the Health Care coverage.

How to make an out-of-province/country claim

There are special rules for claiming the costs of emergency treatment outside of your home province or Canada.

For all medical expenses, complete the applicable forms, making sure all required information is included. Attach all initial receipts and forward to Canada Life after the expense is incurred. This will enable Canada Life to co-ordinate payment directly with the hospital and/or medical provider involved, providing the insured person gives approval to Canada Life to co-ordinate payment with the Provincial Health Care plan. It is very important that you send your claims to the Canada Life Out-of-Country Claims Department immediately as your Provincial Health Care Plan has very strict time limitations.

If a medical provider or hospital bills you directly, send the bill along with your claim form to Canada Life Out-of-Country Claims Department.

What you are not covered for under any Health Care coverage

We can decline a claim for services or supplies that were purchased from a provider that is not approved by us.

We can limit the covered expense for a service or supply to that of a lower cost alternative service or supply that represents reasonable treatment.

We will not pay for the cost of:

- services or supplies associated with a covered service or supply, unless specifically listed as a covered service or supply determined by us to be a covered service or supply
- health care services or supplies that the insured person is eligible to claim under Workers' Compensation legislation in the insured person's province of residence
- health care services or supplies required due to intentionally self-inflicted injury
- health care services or supplies required as the result of war, rebellion, or hostilities of any kind, whether or not the insured person is a participant
- health care services or supplies required as the result of participation in a riot or civil disturbance
- health care services or supplies due to committing a criminal offence or provoking an assault
- services required by a court, the insured person's employer, a school or anyone other than the insured person's physician (For example, the insured person's employer requiring a doctor's note or a court requiring that the insured person receive psychological services.)
- drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital
- services or supplies that Canada Life has determined are not proportionate to the disease or injury or, where applicable, the stage or progression of the disease or injury. In determining whether a service or supply is proportionate, Canada Life may take any factor into consideration including, but not limited to, the following:
  - clinical practice guidelines;
  - assessments of the clinical effectiveness of the service or supply, including by professional advisory bodies or government agencies;
  - information provided by a manufacturer or provider of the service or supply; and
  - assessments of the cost effectiveness of the service or supply, including by professional advisory bodies or government agencies.

Prior Authorization

In order to determine whether coverage is provided for certain services and supplies, we will maintain a limited list of services or supplies that require prior authorization.

These services and supplies, including a listing of the prior authorization drugs, can be found on the Canada Life website as follows:
www.canadalife.com/001/Client_Services/Group_Plan_Members/Forms/Prior_Authorizations_Forms/index.htm

Prior authorization is intended to help ensure that a service or supply represents reasonable treatment.

If the use of a lower cost alternative service or supply represents reasonable treatment, an insured person may be required to provide medical evidence why the lower cost alternative service or supply cannot be used before coverage may be provided for the service or supply.

Health Case Management

If you apply for prior authorization of certain supplies or services, Canada Life may contact you to participate in health case management. Health case management is a program recommended or approved by Canada Life that may include but is not limited to:

- consultation with you and the attending physician to gain understanding of the treatment plan recommended by the attending physician;
- comparison with the attending physician, of the recommended treatment plan with alternatives, if any, that represent reasonable treatment;
- identification to the attending physician of opportunities for education and support; and
- monitoring your adherence to the treatment plan recommended by the attending physician.

In determining whether to implement health case management, Canada Life may assess such factors as the service or supply, the medical condition, and the existence of generally accepted medical guidelines for objectively measuring medical effectiveness of the treatment plan recommended by the attending physician.

Health Case Management Limitation

Canada Life can, on such terms as it determines, limit the payment of benefits for a service or supply where:

- Canada Life has implemented health case management and you do not participate or cooperate; or
- you have not adhered to the treatment plan recommended by the attending physician with respect to the use of the service or supply.

Health Case Management Expense Benefit

Expenses associated with health case management may be paid for by Canada Life at its discretion. Expenses claimed under this provision must be pre-authorized by Canada Life.

Designated Provider Limitation

For a service or supply to which prior authorization applies or where we have recommended or approved Health Case Management, we can require that a new service or supply be purchased from or administered by a provider designated by us, and:

- limit the covered expenses for a service or supply that was not purchased from or administered by a provider designated by us to the cost of the service or supply had it been purchased from or administered by the provider designated by us; or
- decline a claim for a service or supply that was not purchased from or administered by a provider designated by us.

Patient Assistance Program

A patient assistance program may provide financial, educational or other assistance to you with respect to certain services or supplies.

If you are eligible for a patient assistance program, Canada Life may require you to apply to and participate in such a program. Where financial assistance is available from a patient assistance program that Canada Life requires participation in, Canada Life will reduce the amount of a covered expense for a service or supply by the amount of financial assistance you are entitled to receive for that service or supply.

Submitting a claim

You may submit all Health Care claims online. To use the online service you will need to be registered for My Canada Life at Work and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

Online claims must be submitted to Canada Life as soon as possible, but no later than 15 months after you incur the expense.

You must retain your receipt for 12 months from the date you submit your claim to Canada Life as a record of the transaction, and you must submit it to Canada Life on request.

For claims not submitted online, access My Canada Life at Work to obtain a personalized claim form or obtain a copy of the claim form that is available from your employer. Complete this form making sure it shows all the required information.

Make sure that your receipts include:

- the name of the person who received the service or supply
- the date the service or supply was received
- the type of service or supply and
- the cost

We must receive satisfactory proof of claim by the earlier of the following dates:

- June 30th of the year following the date of service or the date of purchase, or
- 90 days after the date the policy terminates.

Your Dental coverage

What is Your Dental coverage

We pay for the covered dental care charges that are incurred while the person is covered and care was provided by a licensed dentist, denturist, dental hygienist entitled by law to practice independently, anaesthetist or specialist. When we use the term “dentist” in this provision, we intend it to include all of the above.

How much we will pay

The amount we will pay is based on the current Dental Association Fee Guide for General Practitioners or Dental Hygienist Fee Guide.

We base coverage on the cost of the least expensive treatment that could be used to treat or prevent the dental problem. If the cost of the dental work given is more than the cost of the least expensive treatment, we will only cover the cost of the least expensive treatment.

We will pay a percentage of the covered dental costs, up to any maximum amounts stated in the description of the benefit. Before we pay a benefit under this coverage, you must pay the deductible amount if any.

There is no deductible for covered dental costs.

The following is an overview of what we will pay. Please see the "What you are covered for" section for specific details.

Preventive coverage

100% of Preventive covered costs with no deductible.

Maintenance coverage

100% of Maintenance covered costs with no deductible.

The maximum we will pay for Preventive and Maintenance covered costs combined is unlimited.

Major restorative coverage

50% of Major restorative covered costs with no deductible. The maximum we will pay is $1,000 per covered person in a calendar year.

Orthodontic coverage

50% of Orthodontic covered costs with no deductible. The maximum we will pay is $3,000 per covered person in a lifetime.

Limitation

If you enrol more than 31 days after the end of the waiting period for coverage, the maximum amount payable to you for charges incurred during the first twelve months of coverage will be $250. The full coverage offered under this Dental coverage provision will begin after twelve months.

Please refer to the "General Terms" section for details on the waiting period for coverage and enrolment procedures.

When your Dental coverage ends

Please see "When your coverage ends" in the "General Terms" section for additional terms that apply when your coverage ends.

When your Dental treatment will cost more than $500

If the cost of any dental treatment will be more than $500, we recommend that you send us a "pre-determination" before the treatment is started. A pre-determination is a report describing the proposed treatment and cost. We will determine how much of the treatment is covered and give a written estimate of how much the covered person will be responsible to pay before the treatment begins.

We may also need the following information:

- a fully completed written estimate; and
- pre-operative x-rays, study models, and laboratory reports.

If we ask for the above information, we cannot process the pre-determination or pay any claim until we receive it.

What you are covered for

Dental coverage is made up of various types of coverage. We have included detailed descriptions of each type below.

Preventive coverage

These are procedures used to treat or help prevent basic dental problems. Some of the procedures are examinations, x-rays, fluoride treatment and fillings.

1. Examinations

A. Initial or Complete Examinations

A complete examination includes examination and charting of the teeth, gums and underlying bone, pulp vitality tests, recording the history of the patient's dental work and planning a treatment.

One complete examination is covered per lifetime, once per general practitioner.

B. Recall Examinations

A recall examination includes a complete examination of the teeth, gums and underlying bone, pulp vitality tests, checking occlusion and consulting with the patient.

One recall examination is covered every six months.

C. Specific Examinations

A specific examination may include an examination of the teeth or a specific tooth, gums and underlying bone, pulp vitality tests and checking occlusion.

One specific examination is covered once every six months.

D. Emergency Examinations

An emergency examination includes checking for pain or infection and pulp vitality tests.

E. Consultation

This is a visit to the covered person's dentist to discuss a serious dental problem and to agree on a treatment plan and is covered for up to $50 per consultation.

2. X-rays

A. Full Mouth Series X-rays

Full mouth x-rays are a series of at least 16 films including bitewings. One series is covered every 36 months.

B. Panorex X-rays

A panorex is one view of the entire mouth and is covered once every calendar year.

C. Periapical X-rays

Periapical x-rays are x-rays of single teeth. These are limited to the maximum amount payable for 13 films per covered person per calendar year.

D. Bitewing X-rays

A bitewing x-ray is used to detect decay in molar teeth. One set of bitewing x-rays are covered every 6 months.

E. Bite X-rays

Bite x-rays are x-rays of the chewing surface of the teeth. These x-rays show the fit between the upper and lower teeth when they are in contact. There is no limit to the number of bite x-rays the covered person is covered for.

3. Tests

A. Biopsy of Oral Tissue

A biopsy occurs when a small piece of tissue is removed and sent to a laboratory to be tested for disease. There are no limits.

B. Pulp Vitality Test

The pulp is the soft tissue inside a tooth. This test is performed to see if the pulp is healthy. One pulp vitality test per tooth is covered if the test is done more than 30 days prior to a root canal therapy.

4. Unmounted Study Models

These are diagnostic casts or models of the upper and lower teeth, each separate from the other. These are used for diagnostic ability or for construction of impression trays and temporary bridges and partial denture. These are limited to one set per calendar year.

5. Cavity Prevention

A. Polishing or Cleaning Teeth

One unit (15 minutes) is covered each visit and up to one treatment every six months.

B. Recall Scaling

One unit (15 minutes) is covered each visit and up to one visit every six months as part of the Recall Package. (For periodontal scaling, please see the "Treatment of gums" section.)

C. Fluoride

Fluoride is a substance which is applied to the teeth to strengthen the enamel and prevent decay in primary and permanent teeth. The covered person is covered for one treatment every six months.

D. Recall Package

Recall Package includes polishing, recall scaling and recall examinations. It may also include fluoride and is covered once every six months.

E. Pit and Fissure Sealants

This is a coating put on top of any pits or cracks in teeth to prevent cavities from forming. There is no limit to the number of treatments the covered person is covered for.

6. Space Maintainers

A. Space Maintainers

A space maintainer is an appliance that a dentist uses to maintain a space where a tooth has been removed.

B. Maintenance of space maintainers

Maintenance of a space maintainer means adjusting, recementing or repairing an appliance used to maintain a space where a tooth has been removed.

7. Fillings

Please note: These procedures may include local anaesthesia, removal of decay, pulp protection (a sedative used to protect the nerve) and bite adjustment (work done to make sure that the fit between the top and bottom teeth is correct). The cost of finishing or polishing is not covered.

All restoration done to the same tooth will be covered as a single visit to the dentist.

A. Amalgam Fillings

These are silver fillings that are used to restore teeth. If a bonded silver filling is installed, we will only cover the cost of a non-bonded silver filling.

B. Composite Fillings

These are white filling that are used to restore teeth.

C. Veneer Applications

Veneers are white facings put on a tooth's surface. Veneer applications that are done for cosmetic purposes are not covered.

D. Retentive Pins

These are pins used to make sure that a restoration or filling stays in place.

E. Pre-fabricated Posts

These are pre-made posts used for additional support to the tooth after root canal treatment.

F. Sedative Fillings for Caries, Trauma and Pain Control

Caries result from tooth decay. Trauma means a blow to the mouth or teeth resulting in injury. Severe wear may be considered a traumatic injury. Pain control includes temporary fillings and local anaesthesia to reduce pain before a permanent filling is installed.

Sedative fillings that are applied to reduce pain are covered. This procedure includes local anaesthesia, removal of decay and/or removal of existing restoration, bite adjustment (treatment to make sure that the fit between the top and bottom teeth is correct), pulp cap (a sedative placed on an exposed nerve to reduce pain and prevent infection) and placement of a sedative filling (a sedative placed under a filling to reduce pain).

G. Stainless Steel, Plastic and Polycarbonate Caps

This is a cap that is installed to cover the whole tooth or teeth. These are limited to once in 5 years.

8. Bite Adjustment/Equilibration

This is a procedure to correct the bite problem between the upper and lower teeth when they are in contact. Bite adjustments are covered for up to eight units every calendar year.

9. Minor Oral Surgery

Please note: These procedures may include local anaesthesia, appropriate x-rays, surgery and follow-up care.

A. Extractions

Extraction means removing a tooth, including an impacted tooth. There is no limit to the number of extractions per visit.

B. Residual Root Removal

Residual root removal means removing tooth roots left behind when a tooth is extracted. One root removal is covered per tooth in a lifetime.

Maintenance coverage

Some of the procedures that are covered for are root canal therapy and major oral surgery.

1. Major Oral Surgery

Please note: These procedures may include local anaesthesia, appropriate x-rays, surgery and follow-up care.

Treatment for these procedures are unlimited as long as they are not for cosmetic purposes and are not part of any implant (supports for artificial teeth surgically placed in the jaw bone) or part of any orthognathic surgery, remodelling or repositioning of the lower jaw.

A. Surgical Exposure

This is surgical incision to expose teeth that will not erupt or come on time.

B. Alveoloplasty, Gingivoplasty, Stomatoplasty, Vestibuloplasty

Alveoloplasty means remodelling, removing or reducing bone. Gingivoplasty means remodelling gums. Stomatoplasty means remodelling the floor of the mouth. Vestibuloplasty involves ridge reconstruction.

C. Surgical Excision

This includes the removal of cysts or a foreign body.

D. Surgical Incision

This is an incision made to an infected area usually to allow drainage.

E. Fractures

The treatment of fractures of the upper or lower alveolar bone which holds the teeth in the sockets.

F. Frenectomy

Frenectomy involves surgery on the frenum (a thin tissue that connects the lips to the gums and the tongue to the floor of the mouth).

F. Sialolithotomy

This is the partial removal of the salivary duct.

G. Antral Surgery

This is the surgical removal of a tooth that has been forced up into a sinus cavity.

H. Hemorrhage Control

This is treatment to stop bleeding resulting from an extraction or trauma.

I. Post Surgical Care

This is treatment given by the dentist after surgery until healing is complete.

2. Treatment of roots

A. Pulpotomy

Pulpotomy is the removal of dental pulp from the crown portion of the tooth. This procedure may include a treatment plan, anaesthesia, the treatment, appropriate x-rays, and follow-up care and must occur more than 30 days before a root canal therapy.

B. Pulpectomy

Is the removal of the tissue from the pulp chamber and this procedure may include a treatment plan, anaesthesia, the treatment, appropriate x-rays, and follow-up care and must occur more than 30 days before a root canal therapy.

C. Root Canal Therapy

This procedure includes:

- treatment plan
- pulp vitality test
- pulpectomy (removing the diseased nerve from inside the tooth to reduce pain)
- opening and drainage
- tooth isolation and
- clinical procedure with appropriate x-rays

One root canal therapy is covered per tooth in a lifetime. Retreatment procedures are not covered.

If dental coverage ends during root canal therapy, we will extend coverage for 30 days to complete the root canal service. If the dental coverage is replaced by another plan before the procedure is completed, the replacing plan will be responsible for the cost of the entire procedure.

D. Apexification

Apexification means closing the root of a tooth with hard tissue. This procedure may include a treatment plan, anaesthesia, tooth isolation, the treatment with appropriate x-rays, placement of dentogenic media (material which causes a root tip to form in young teeth so that root canal therapy can be done), and follow-up care. Apexification is covered once per tooth in a lifetime.

E. Retrofilling

This is a filling done through the root end and is covered once per tooth in a lifetime.

F. Apicoectomy

This is the surgical removal of a root end after root canal therapy and is covered once per tooth in a lifetime.

G. Root Amputation

Root(s) from a tooth may have to be removed because of infection. However, the crown and at least one root remains so that the tooth does not have to be removed and is covered once per tooth in a lifetime.

H. Hemisection

Hemisection means removing a portion of the root(s) and the crown of a tooth but leaving the other root(s) in place and is covered once per tooth in a lifetime.

I. Bleaching Endodontically Treated Tooth/Teeth

This is the whitening of a tooth internally through the root canal opening of a tooth.

J. Intentional Removal, Apical Filling and Reimplantation

This is the intentional removal of a healthy tooth and implanting it. For example, a third molar is removed and used to replace a missing first molar. The covered person is covered for one procedure per tooth in a lifetime.

3. Treatment of gums

Please note: These procedures may include local anaesthesia, surgical dressing, sutures and follow-up care for one month. Post-treatment evaluation is not covered.

A. Displacement Dressing

A displacement dressing means placing a medicated pack on inflamed gums to move gums away from the calculus (deposits on teeth that irritate gums).

B. Desensitization

Desensitization means applying fluoride to reduce sensitivity.

C. Gingival Curettage

Gingival curettage means scraping out damaged tissue inside the gums.

D. Gingivectomy

Gingivectomy means removing damaged gum tissue.

E. Flap Surgery

Flap surgery is the opening made for bone removal.

F. Tissue Graft

Tissue graft is the transfer of healthy gums to an area where the gums have receded.

G. Periodontal Scaling and/or Root Planing (Tartar Removal)

Scaling means removing calcium deposits on teeth. Root planing means the smoothing of rough tooth surfaces and removing any calcium deposits and is covered for up to 12 units of scaling and/or root planing every calendar year.

4. Appliances and Appliance Adjustment

A. Periodontal Appliances

A periodontal appliance is a plastic appliance which covers the chewing surfaces of either the upper or the lower (or both) teeth to protect the teeth from damage caused by grinding.

B. Adjustment of Periodontal Appliances

This is done to confirm or adjust the bite of the upper and lower teeth with the periodontal appliance in the mouth.

5. Denture Maintenance

A. Denture Adjustments

Adjustments are covered and unlimited as long as the adjustments are made more than three months after the new dentures were first inserted.

B. Denture Repairs

Repairing dentures means fixing broken or damaged dentures and is unlimited.

C. Denture Rebasing and Relining

Rebasing dentures means fitting dentures with a new base. Relining dentures means adding material so that the dentures fit properly.

D. Tissue Conditioning

Tissue conditioning means applying a conditioner to the alveolar ridge that ensures a proper denture fit.

Major Restorative Coverage

These are procedures used to treat major dental problems. Some of the procedures are dentures, denture maintenance, post and core, crowns, bridgework, inlays, onlays and veneers.

1. Caps and Tooth Coverings

Please note: These procedures may include treatment planning, bite records, local anaesthesia, subgingival preparation of the tooth (work done below the gum line), removal of decay and old restoration, tooth preparation, pulp protection (a sedative used to protect the nerve), impressions, temporary services, insertion, bite adjustments (work done to make sure that the fit between the top and bottom teeth is correct) and cementation.

Crown lengthening (subgingival preparation) before tooth preparation is not an eligible benefit.

If the covered person's coverage ends after a tooth has been prepared for a crown, inlay, onlay or veneer but before the procedure has been finished, we will extend coverage for 90 days to complete the procedure even if the dental coverage is replaced by another plan.

Charges for replacing an existing crown, veneer, inlay, or onlay will only be paid if such replacement is for an equivalent bridge and meets one of the conditions shown below:

- it has been more than 60 months since the last crown, veneer, inlay or onlay was inserted; or
- it has been less than 60 months since the last crown, veneer, inlay or onlay was inserted and the existing crown, veneer, inlay or onlay is no longer wearable. We must approve this.

A. Inlay/Onlay Restorations

Inlays and onlays are metal or porcelain casts placed on the surface of the tooth.

B. Crowns

A crown is a cap that covers the whole tooth.

C. Laboratory Processed Veneer Applications

Veneers are white facings put on a tooth's surface. Veneer applications that are done for cosmetic purposes are not covered.

D. Retentive Pins in Inlays, Onlays and Crowns

These pins are used to make sure that the inlays, onlays or crowns stay in place.

E. Build-up/Fillings

This means restoring a tooth prior to capping for better adaptation of the cap.

2. Dentures

Please note: These procedures may include treatment plan, initial and final impressions, jaw relations records, try-in insertion, bite equilibration (work done to make sure that the fit between the top and bottom teeth is correct), and three month follow-up care.

If coverage ends after preparations have been made for a denture(s) but before the procedure has been finished, we will extend coverage for 90 days to complete the denture(s), even if the dental coverage is replaced by another plan.

If the covered person is covered by this plan on the date that the denture is installed, we will continue to cover the cost even if this plan is replaced by another plan.

A. Complete Dentures

Complete dentures means dentures that replace either all of the top teeth or all of the bottom teeth.

Charges for replacing an existing denture will only be paid if such replacement is for an equivalent denture and meets one of the conditions shown below:

- it has been more than 60 months since the last complete dentures was inserted; or
- it has been less than 60 months since the last complete dentures was inserted and the existing denture is no longer wearable. We must approve this.

B. Transitional Dentures

Transitional dentures are temporary dentures used for healing purposes due to the extraction of one or more teeth. Permanent dentures must be inserted within 12 months of the date the temporary dentures were inserted.

C. Acrylic Denture

Acrylic dentures are dentures with an acrylic denture base. Acrylic dentures are covered only if it has been more than 60 months since the last acrylic dentures were inserted.

D. Partial Dentures

Partial dentures replace one or more top or bottom teeth. They may be acrylic (plastic), metal or chrome base that can have acrylic, wire or chrome clasps (which hold on to the teeth). Partial dentures are covered only if it has been more than 60 months since the last partial dentures were inserted or additional teeth have been extracted.

3. Bridges

Please note: These procedures may include treatment planning, bite records, local anaesthesia, subgingival preparation of the tooth (work done below the gum line), removal of decay and old restoration, tooth preparation, pulp protection (a sedative used to protect the nerve), impressions, temporary coverage, splinting, insertion, bite adjustments (work done to make sure that the fit between the top and bottom teeth is correct) and cementation.

Crown lengthening (subgingival preparation) before tooth preparation is not an eligible benefit.

If the covered person's coverage ends after a tooth has been prepared for a bridgework but before the procedure has been finished, we will extend coverage for 90 days to complete the bridgework even if the dental coverage is replaced by another plan.

Charges for replacing an existing bridge will only be paid if such replacement is for an equivalent bridge and meets one of the conditions shown below:

- it has been more than 60 months since the last bridge was inserted; or
- it has been less than 60 months since the last bridge was inserted and the existing bridge is no longer wearable. We must approve this.

A. Pontics

A pontic is an artificial tooth that replaces a missing tooth. Pontic replacement is covered only if it has been more than 60 months since the last pontic was installed in that space. A porcelain pontic installed on a molar is not covered.

B. Retainers/Abutments

A retainer/abutment is the tooth beside the missing tooth that will be used to support the bridge. The preparation of the tooth is covered only if it has been more than 60 months since the last preparations were made to that tooth.

C. Bridgework Repairs

Repairing bridgework means fixing or repairing damaged bridgework.

D. Posts in Retainers/Abutments

These are posts and cores used for additional support to the retainer/abutment. Posts and cores are covered only if it has been more than 60 months since the last installation to that tooth.

Orthodontic Coverage

These are procedures used to correct crooked or misaligned teeth. This includes all necessary dental treatment needed to correct this problem such as examinations, x-rays, models, photographs, reports and surgical exposure of teeth, appliances and adjustments.

We require that a treatment plan prepared by the dentist be sent to us. We will then pay up to 30% of the cost at the beginning of treatment, minus the diagnostic fee. We will calculate the remaining payments by dividing the rest of the cost by the number of months in the treatment plan. We will pay monthly or quarterly, depending on when the dentist bills us or when we receive the receipts. We will not make any advance payments.

The cost of dental treatment that is not an orthodontic service but is needed because of the orthodontic treatment will be included and covered as if it were an orthodontic service.

What you are not covered for

We will not pay for:

- dental services or supplies that the covered person is eligible to claim under the Workers' Compensation legislation
- any dental charges not included in the current Dental Association Fee Guide for General Practitioners or Dental Hygienist Fee Guide
- cosmetic procedures
- charges for appointments that are not kept
- charges for completing claim forms
- treatment to correct temporomandibular joint dysfunction (The hinge joint of the jaw is called the temporomandibular joint.)
- any endodontic treatment which was started before the effective date of coverage
- the replacement of dental appliances that are lost, misplaced or stolen
- any treatment related to orthognathic surgery (remodelling or reconstruction of your jaw)
- procedures or supplies used in vertical dimension corrections (changing the height of the teeth) or to correct attrition problems (worn down teeth);
- implanting fabricated teeth or any major surgery resulting from implanting fabricated teeth
- any crowns, bridges or dentures for which tooth preparations were started before the effective date of coverage
- any orthodontic services received before the effective date of coverage
- experimental treatment or testing

Submitting a claim

For claims submitted online, access My Canada Life at Work to obtain a personalized claim form or obtain a copy of the claim form that is available from your employer and have your dental service provider complete the form. The completed claim form will contain the information necessary to enter the claim online. To use the online service you will need to be registered for My Canada Life at Work and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

Online claims must be submitted to Canada Life as soon as possible, but no later than 15 months after you incur the expense.

You must retain your receipt for 12 months from the date you submit your claim to Canada Life as a record of the transaction, and you must submit it to Canada Life on request.

For claims not submitted online, access My Canada Life at Work to obtain a personalized claim form or obtain a copy of the claim form that is available from your employer and have your dental service provider complete the form.

Your employer may have made arrangements to allow your dental service provider to send claims to us electronically. If so, you will not have to fill out a claim form and we will make the payment to the person designated. Once payment has been made, we will send an explanation of our payment.

We will pay benefits to you when we receive satisfactory proof of claim.

We must receive all claims by the earlier of the following dates:

- June 30th of the year following the treatment, or
- 90 days after the date the plan terminates

Your Short Term Disability coverage

In this section, you and your mean the employee.

What is Short Term disability coverage

If you become disabled while insured under this policy and suffer a loss of earnings as a result, you may be eligible for Short Term Disability payments subject to all of the terms of this coverage.

Short Term Disability premiums will not have to be paid while you are receiving Long Term Disability payments under the "Long Term Disability coverage" section of this policy provided this Short Term Disability coverage section remains in force.

What is the definition of disability

When used in this Short Term Disability section, disabled means because of disease or injury, there is no combination of duties you can perform that regularly took at least 60% of your time at work to complete. Disability is assessed on the basis of the duties you regularly performed for the employer before disability started. The availability of work is not considered when assessing disability.

If disease or injury prevents you from performing a duty, it will also be considered to prevent you from performing

- others that are performed only in order to complete that duty; and
- others that can only be performed after that duty is completed.

How much we will pay

66.67% of weekly earnings, rounded to the next dollar, up to a maximum of $2,300 per week.

Proof of insurability must be provided by you and approved by us for any amount of coverage over $1,850 per week.

We will make Short Term Disability payments weekly in arrears.

We will calculate how much we will pay based on all of the following:

- the amount of coverage that is in effect at the start of your continuous period of disability
- less than half of one day will not be considered a day of disability
- the amount of coverage will be based on the lesser of your actual earnings and the level of earnings on which the premium for this coverage was paid
- the amount of the payment is the amount of your coverage reduced by any amount described in the "When we reduce your payments" section

If you are disabled for any part of a week, we will pay 1/5 of the amount of the weekly payment for each regular work day you are disabled.

A regular work day is any day you are scheduled to work or would be scheduled to work if it were not a holiday or vacation day.

Tax status

Payments are non-taxable.

Waiting period for payments

Accident

If you are disabled by an accident, there will be a waiting period of seven consecutive days. When used in this Short Term Disability section, accident means a bodily injury that occurs solely as a direct result of a sudden and unexpected action from an outside source.

Illness or injury

If you are disabled by an illness or injury, there will be a waiting period of seven consecutive days.

If you do not see a physician during the waiting period, you will only be eligible for payments from the date you saw a physician.

Start date of disability

Start date of disability means the first regular work day you are unable to work due to the disability.

If you become disabled while on a leave of absence, we will consider the scheduled return-to-work date as the start date of disability. If you have been designated by the employer as working only ten months of the year and become disabled during the period between the end of one school year and the start of another, we will consider the scheduled return-to-work date as the start date of disability. The waiting period for payments begins on that date.

If you become disabled while outside Canada and the United States, we will consider the date you return to Canada or the United States as the start date of disability. The waiting period for payments begins on that date.

When your Short Term Disability payments end

Short Term Disability payments will end on the earliest of the following dates:

- the date you no longer meet the definition of disability
- the date you do not supply us with appropriate medical documentation showing how the illness or injury prevents the performance of the essential duties of your occupation
- the date you engage in work for wages or profit (other than in an approved rehabilitation program)
- the date you have received 26 weeks of weekly payments for a continuous period of disability

When your Short Term Disability coverage ends

Please see "When your coverage ends" in the “General Terms” section for additional terms that apply to when your coverage ends.

What happens if a disability occurs again

If we stop making Short Term Disability payments because you are no longer disabled and you became disabled again within 14 consecutive days due to the same or a related condition, the new period of disability will be considered part of the same continuous period of disability. In such case:

- a new waiting period will not apply
- the payment will be the same as when the first claim ended, and
- payments will not be made beyond the maximum period shown under the “When your Short Term Disability payments end” section

You must re-apply for disability payments by filling out a new claim form.

When we reduce your payments

You may be eligible to apply for and receive benefits from other sources during the disability. For the purpose of any calculations under this provision, we will automatically reduce the disability payments by the full amount of any benefits you are eligible to apply for and receive, before any income tax and/or any other deductions, under:

- any Workers' Compensation Act or similar legislation
- the Canada/Quebec Pension Plan
- to the extent permitted by law, any automobile insurance plan that does not take income benefits under the Employment Insurance Act (Canada) into account when determining benefits

If you receive a lump sum payment from any of the above, we will divide the payment by the number of weeks for which you would have been eligible to receive the benefit and reduce each of our weekly payments by that amount.

If you have not applied for these other benefits, or if your application has not yet been approved, we may estimate the amount you may be eligible to receive and reduce your payments by that amount. If we are notified in writing that your application for these other benefits, or any appeal, has been declined and we determine that this decision should be subject to appeal, you must file an appeal and we may continue to reduce your payments until we are notified in writing that such appeal has been declined.

What you are not covered for

We will not make Short Term Disability payments if a disability results directly or indirectly from:

- self-inflicted injury
- substance abuse unless you are participating in a treatment program approved by us
- war, rebellion or hostilities of any kind whether or not you are a participant
- participation in a riot or a civil disturbance
- committing a criminal offence or provoking an assault
- an accident while you were operating a vehicle, vessel or aircraft, if you
  a) were impaired by drugs or alcohol, or
  b) had a blood alcohol level higher than 80 milligrams of alcohol per 100 millilitres of blood

We will not make Short Term Disability payments if you:

- are on a leave of absence, including maternity/parental leave
- are outside of Canada and the United States, unless we approve the absence
- are working or engaged in any business or occupation for wages or profit
- continue to receive a salary from any employer
- are not under the continuing care of a licensed physician or surgeon
- are not receiving treatment that we consider appropriate
- do not attend an examination by a physician of our choice
- are receiving severance pay, a damages award or other payment due to termination of the employment relationship. If any such payment or award is received in a lump sum, we will stop making Short Term Disability payments for a period equal to the number of weeks the lump sum amount represents relative to your pre-disability earnings

Submitting a claim

We must receive proof of claim within 90 days after the disability began, or 90 days after the plan terminates, whichever occurs earlier.

Your Long Term Disability Coverage

In this section, you and your mean the employee.

What is Long Term Disability coverage

If you become disabled while covered under the policy, you may be eligible for Long Term Disability payments subject to all of the terms of this coverage.

Once you have completed the waiting period and are receiving Long Term Disability payments, premiums will not be required from your start date of disability.

What is the definition of disability

During the first 24 months of payments, you will be considered disabled if unable to perform the essential duties of your own job for any employer due to illness or injury. The availability of work is not considered when assessing disability. You are not considered disabled if you can perform a combination of duties that regularly took at least 60% of your time to complete.

After 24 months of payments, you will be considered disabled due to illness or injury if you are unable to perform the essential duties of any occupation for any employer for which you are qualified or could reasonably become qualified based on education, training or experience. The availability of work is not considered when assessing disability.

You must also be unable to earn the same percentage of the monthly earnings used to calculate the payment amount in the "How much we will pay" section.

How much we will pay

67% of monthly earnings, rounded to the next dollar, up to a maximum of $4,500 per month.

If you are disabled for part of any month, we will pay 1/30th of the monthly payment for each full day you are disabled. Payments will be made monthly in arrears.

We will calculate how much we will pay based on all of the following:

- the amount of coverage that is in effect at the start of your continuous period of disability
- the amount of coverage will be based on the lesser of your actual earnings and the level of earnings on which the premium for this coverage was paid
- the amount of the payment is the amount of your coverage reduced by any amount described in the "When we reduce your payments" section

Tax status

Payments are non-taxable.

Waiting period for payments

There will be a waiting period of 182 days of disability before you are eligible to receive Long Term Disability payments.

What happens if a disability occurs again

If you return to work for 30 days or less during the waiting period and again stop working because of the same or a related condition, the waiting period for payments will continue from where it left off.

If you cease to be disabled while Long Term Disability payments are being made and you become disabled again within six months due to the same or a related condition, the new period of disability will be considered part of the same continuous period of disability. In this case:

- a new waiting period will not apply
- the payment amount will be the same as when the first claim ended, and
- payments will not be made beyond the maximum period shown under the "When your Long Term Disability payments end" section

You must re-apply for disability payments by filling out a new claim form.

Start date of disability

Start date of disability means the first full day you are unable to work due to the disability.

If you become disabled while on a leave of absence, we will consider the scheduled return-to-work date as the start date of disability. If you have been designated by the employer as working only ten months of the year and become disabled during the period between the end of one school year and the start of another, we will consider the scheduled return-to-work date as the start date of disability. The waiting period for payments begins on that date.

If you become disabled while outside Canada and the United States, we will consider the date you return to Canada or the United States as the start date of disability. The waiting period for payments begins on that date.

When your Long Term Disability payments end

Long Term Disability payments will end on the earliest of the following dates:

- the date you no longer meet the definition of disability
- the date you do not supply us with appropriate medical documentation showing that you continue to meet the definition of disability
- the date you engage in work for wages or profit (other than in an approved rehabilitation program)
- the date you refuse to participate or stop participating in a rehabilitation program, recommended by us
- the date you reach age 65, or
- the date you die

However, provided you are under 65 years of age when the disability begins, disability payments will be made for at least 12 months while the disability continues.

When your Long Term Disability coverage ends

When you reach age 65.

Please see "When your coverage ends" in the "General Terms" section for additional terms that apply to when your coverage ends.

When we reduce your payments

You may be eligible to apply for and receive benefits from other sources during the disability. For the purpose of any calculations under this provision, we will automatically reduce your disability payments by the full amount of any benefits you are eligible to apply for and receive, before any income tax and/or any other deductions, under:

- any Workers' Compensation Act or similar legislation
- the Canada/Quebec Pension Plan or a similar plan of any other country, excluding child benefits to which any member of your family is entitled to apply for and receive as a result of your disability
- any provincial motor vehicle accident insurance plan that does not take Employment Insurance benefits into account when calculating its benefits
- any employer sponsored salary continuance or Short Term Disability coverage

Your payments will also be reduced so that payments from all sources will not exceed 85% of your net pre-disability monthly earnings. For the purpose of any calculation under this provision, we will consider the full amount of any benefits you are eligible to apply for and receive, before any income tax and/or any other deductions:

- under this policy
- under any Workers' Compensation Act or similar legislation
- under the Canada/Quebec Pension Plan (including child benefits to which any member of your family younger than 18 years of age is entitled to apply for and receive as a result of your disability), or a similar plan of any other country

- under any provincial motor vehicle accident insurance plan that does not take Employment Insurance benefits into account when calculating its benefits
- under any employer sponsored salary continuance or Short Term Disability coverage
- from any group plan, including any payments resulting from your membership in any association
- any retirement income provided under any retirement or pension plan of your employer
- under any other government plan, law or agency for the same or a subsequent disability, excluding Employment Insurance or its successors
- from any type of employment

If you have not applied for these other benefits, or if your application has not yet been approved, we may estimate the amount you may be eligible to receive and reduce your payments by that amount. If we are notified in writing that your application for these other benefits, or any appeal, has been declined and we determine that this decision should be subject to appeal, you must file an appeal and we may continue to reduce your payments until we are notified in writing that such appeal has been declined.

If you receive a lump sum payment from any of the above, we will divide the payment by the number of months for which you would have been eligible to receive the benefits and reduce each of our monthly payments by that amount.

Pre-disability earnings

Pre-disability monthly earnings means your monthly earnings on the day before the start date of disability. Net pre-disability monthly earnings means your monthly earnings on the day before the start date of disability after income tax has been deducted.

What is a Rehabilitation Program

Rehabilitation programs are designed to help you recover faster and return to work.

Rehabilitation programs may include returning to work on a part-time basis or returning to modified duties. You may be able to upgrade job skills and learn about searching for a new job or writing resumes.

We may pay for the cost of any special services or equipment you need to participate in a rehabilitation program. We will decide if a rehabilitation program is appropriate and we must approve any expenses in writing before they are incurred.

You will continue to receive adjusted disability payments while participating in a rehabilitation program. The payment amount you will receive while participating in a rehabilitation program is explained in the "What is a Return-to-Work Allowance" section.

If you are reasonably suited to participate in a rehabilitation program and refuse to do so, we will stop making Long Term Disability payments.

What is a Return-to-Work Allowance

If you receive earnings from employment that is part of an approved rehabilitation program, payments will not be reduced unless your income from all sources exceeds 100% of net pre-disability earnings. If income from all sources exceeds 100% as indicated above, Long Term Disability payments will be reduced by the amount in excess of 100%.

After 12 months, your Long Term Disability payments will be further reduced in direct proportion to the percentage difference of your net earnings under the rehabilitation program compared to your net pre-disability earnings. For example, if your net rehabilitation earnings are 30% of your net pre-disability earnings, your Long Term Disability payments will be reduced by 30%.

What you are not covered for

We will not make Long Term Disability payments if a disability results directly or indirectly from:

- intentionally self-inflicted injury
- substance abuse unless you are participating in a treatment program approved by us
- war, rebellion or hostilities of any kind whether or not you are a participant
- participation in a riot or a civil disturbance
- committing a criminal offence or provoking an assault
- an accident while you were operating a vehicle, vessel or aircraft, if you
    a) were impaired by drugs or alcohol, or
    b) had a blood alcohol level higher than 80 milligrams of alcohol per 100 millilitres of blood

We will not make Long Term Disability payments if you:

- are on a leave of absence, including maternity/parental leave
- are outside of Canada and the United States, unless we approve the absence
- refuse to participate or stop participating in a rehabilitation program or return-to-work program for which you are reasonably suited
- are not under the continuing care of a licensed physician or surgeon
- are not receiving treatment that we consider appropriate
- do not attend an examination by a physician of our choice
- are in a psychiatric facility, jail, prison or any correctional facility, because of a criminal offence
- are receiving severance pay, a damages award or other payment due to termination of the employment relationship. If any such payment or award is received in a lump sum, we will stop making Long Term Disability payments for a period equal to the number of months the lump sum amount represents relative to your pre-disability earnings

Submitting a claim

We must receive proof of claim within 90 days after the end of the Long Term Disability waiting period, or 90 days after the policy terminates, whichever occurs earlier.

Life coverage

Your Life coverage

In this section, you and your mean the employee.

What is Your Life coverage

If you die while covered under the policy, we will pay the amount of Employee Life coverage to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements to your beneficiary.

How much we will pay

Two times your annual earnings, rounded to the next $1,000, up to a maximum of $200,000. We will base the amount of coverage on your actual annual earnings or the amount of annual earnings that premiums have been paid on, whichever is less.

Reduction

When you reach age 65, the amount of your Employee Life coverage will be reduced by 50%.

When Your Employee Life coverage ends

When you reach age 70.

Please see "When your coverage ends" in the "General Terms" section for additional terms that apply when your coverage ends.

Your Employee Optional Life coverage

What is Employee Optional Life coverage

If you die while covered under this policy and you have chosen Employee Optional Life coverage, we will pay the amount of Employee Optional Life coverage to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements to your beneficiary.

How much we will pay

Multiples of $10,000, as elected by you, to a maximum of $200,000. Proof of insurability must be provided by you and approved by us.

When Your Employee Optional Life coverage ends

When you reach age 65.

Please see "When your coverage ends" in the "General Terms" section for additional terms that apply when your coverage ends.

Additional Information on Life coverage

Waiver of Premium provision

What happens to the premiums if you become totally disabled

When you become disabled, prior to age 65, we will waive the premiums for your Employee Life and/or Employee Optional Life if you have been disabled for 6 continuous months or were disabled at the time of death. Waiving the premium means your amount of coverage that was in effect at the time of disability will continue without payment of premiums. However we will waive the premiums on the date your claim for Group Long Term Disability payment under this policy is approved.

For the purposes of this coverage disabled means you are unable to perform the essential duties of any occupation for your employer or any other employer for which you are qualified because of education, training or experience. However if your claim for Group Long Term Disability payment under this policy is approved, you will be considered to be disabled.

Your Life coverage will continue under this provision as long as you remain disabled or you reach age 65, whichever occurs earlier.

Termination of the policy will have no effect on your coverage, while premiums are waived.

We must receive proof of disability within twelve months of the start date of your disability. We will require proof of the ongoing disability from time to time. This proof may be medical information from your physicians or a request to be examined by a physician of our choice. If you do not provide the proof of disability within three months of the date we requested it, premiums will no longer be waived.

If you are no longer disabled and you do not return to work with your employer, or you return to work with your employer but the policy has terminated, Life coverage will end. You may have the right to convert your Life coverage. Please refer to the "Converting your Life coverage" section.

Converting Your Life coverage

If you are under age 70 and your Employee Life coverage or your Employee Optional Life coverage under this policy ends for the following reasons:

- your employment ends
- you no longer qualify as an employee
- this policy ends
- your class is no longer covered

you may convert this coverage to individual insurance.

Written application must be made to us accompanied by the first premium within 31 days after coverage ends. This is called the 31-day conversion period. The Individual insurance will not begin until the end of this 31-day conversion period. If you die during the 31-day conversion period, we will pay the maximum amount of insurance you were entitled to apply for.

The premium rate for the individual insurance will be based on:

- the Individual Life and/or Group rates
- the amount of insurance, and
- the age of the person whose life is to be insured on the birthday closest to the date the policy starts.

The individual policy will be one of the standard life insurance conversion policies available by Canada Life or any of its affiliates.

What you are not covered for

We will not pay any amount of Employee Optional Life coverage, if suicide is committed within two years of the date coverage begins and/or is increased.

Submitting a claim

We will pay benefits to you or your beneficiary when we receive satisfactory proof of claim.

Global Medical Assistance Program

This program provides medical assistance through a worldwide communications network which operates 24 hours a day. The network locates medical services and obtains Canada Life's approval of covered services, when required as a result of a medical emergency arising while you or your dependent is travelling for vacation, business or education. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from home. You must be covered by the government health plan in your home province to be eligible for global medical assistance benefits. The following services are covered, subject to Canada Life's prior approval:

- On-site hospital payment when required for admission, to a maximum of $1,000

- If suitable local care is not available, medical evacuation to the nearest suitable hospital while travelling in Canada. If travel is outside Canada, transportation will be provided to a hospital in Canada or to the nearest hospital outside Canada equipped to provide treatment

  When services are covered under this provision, they are not covered under other provisions described in this booklet

- Transportation and lodging for one family member joining a patient hospitalized for more than 7 days while travelling alone. Benefits will be paid for moderate quality lodgings up to $1,500 and for a round trip economy class ticket

- If you or a dependent is hospitalized while travelling with a companion, extra costs for moderate quality lodgings for the companion when the return trip is delayed due to your or your dependent’s medical condition, to a maximum of $1,500

- The cost of comparable return transportation home for you or a dependent and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependent is hospitalized. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation

- In case of death, preparation and transportation of the deceased home

- Return transportation home for minor children travelling with you or a dependent who are left unaccompanied because of your or your dependent’s hospitalization or death. Return or round trip transportation for an escort for the children is also covered when considered necessary

- Costs of returning your or your dependent's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependent from driving, to a maximum of $1,000.

  Limitation

  Benefits will not be paid for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home

Benefits payable for moderate quality accommodation include telephone expenses as well as taxicab and car rental charges.

Limitation

Meal expenses are not covered.

Contact – Employee Assistance Program

The Contact employee assistance program provides you and your dependents with access to confidential counselling and information services.

The services provided under the Contact employee assistance program are available in English and French by dialing 1-866-289-6749.

Services for the hearing impaired are available in English and French by dialling 711.

These lines:

- Are toll-free
- Are staffed 24 hours a day, 7 days a week by intake counsellors who can provide immediate support and counselling, respond to crisis or emergency situations or schedule appointments
- Can be reached from Canada or the United States

For more information on the services available under the Contact employee assistance program, please see the employee assistance program brochure provided by your plan administrator or visit the employee assistance program: https://one.telushealth.com.

Survivor Benefits

If you die while your coverage is still in force, the Contact benefit for your dependents will be continued for a period of 24 months or until they no longer qualify, whichever happens first.

COVERAGE WITH ANOTHER PROVIDER

Basic Accidental Death and Dismemberment Insurance
Policy No. 100007814

Basic Group Critical Illness Insurance
Policy No. 100005769

Voluntary Group Critical Illness Insurance
Policy No. 100007862

Administered by Industrial Alliance Insurance and Financial Services Inc.

Roman Catholic Archbishop of Vancouver (RCAV)
SUMMARY OF INSURANCE COVERAGE
Policy No. 100007814 issued by iA Special Markets, a division of Industrial Alliance Insurance and Financial Services Inc.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

You are covered for a principal sum amount of 2 times your annual salary, rounded to the next higher $1,000 if not already a multiple thereof, to a maximum of $400,000, if an injury is sustained as the result of any accident anywhere in the world - 24 hours per day - on or off the job.

ACCIDENTAL DEATH, DISMEMBERMENT AND SPECIFIC LOSS INDEMNITY

The "loss" or "loss of use" must occur within 365 days of the date of the accident. These benefits are payable on a lump sum basis and in addition to any other benefits you may receive.

	% of Principal Sum
Life	100%
Both Hands or Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye	100%
Speech and Hearing in both Ears	100%
One Arm or One Leg	75%
One Hand or One Foot	66 2/3%
Entire Sight of One Eye	66 2/3%
Speech or Hearing in both Ears	66 2/3%
Thumb and Index Finger of Either Hand	33 1/3%
Four Fingers of Either Hand	33 1/3%
Hearing in One Ear	33 1/3%
All Toes of One Foot	25%
Quadriplegia (total paralysis of all four limbs)	200%
Paraplegia (total paralysis of the lower limbs)	200%
Hemiplegia (total paralysis of one side of the body)	200%

BEREAVEMENT BENEFIT ($1,000)

If an injury results in loss of life, the Company will pay the reasonable and necessary expenses actually incurred by the Spouse and Dependent Children for up to six sessions of grief counselling, by a professional counsellor.

CONTINUATION OF COVERAGE

Coverage can be continued while the insured is on an approved leave of absence, maternity/parental leave, lay-off or disability. This continuation is subject to continued payment of premiums and is granted for a maximum of 12 months (or to age 65 if on disability leave) or on the date the insured returns to work, whichever is earlier.

CONVERSION OPTION

Upon termination of active employment with the Policyholder, an insured may convert his/her insurance to an individual accident insurance plan, with no evidence of insurability, for an amount of principal sum equal to or lower than the amount of principal sum in force at the time of termination. Application for conversion must be made within 31 days. Premiums become payable annually in advance.

CRITICAL DISEASE BENEFIT ($50,000)

If an Insured Person, prior to age 65, is diagnosed by a Specialist with a Covered Disease while this policy is in force and is Totally Disabled from the Covered Disease for at least nine months following the Date of Diagnosis, the Company will pay 10% of the Principal Sum up to a maximum of $50,000.00. This benefit is payable only if investigations leading to the diagnosis of a Covered Disease is initiated more than 90 days following the effective date of insurance with respect to an Insured Person. Payment of the Critical Disease Benefit is limited to only the first Covered Disease to occur.

DAY CARE BENEFIT ($5,000)

If an injury results in loss of life, the Company will pay 5% of the principal sum for each year the dependent child is enrolled in a legally licensed day care (not to exceed 4 years) for each dependent child who is under 13 years of age and enrolled in the day care centre on the date of, or within 12 months following the accident.

EDUCATION BENEFIT ($5,000)

If an injury results in loss of life, the Company will pay 5% of the principal sum for each year the dependent child continues education as a full-time student in an institution of higher learning beyond the secondary school level (not to exceed 4 years) for each dependent child who was enrolled as a full-time student in an institution of higher learning beyond the secondary school level, or at the secondary school level but enrolls in an institution of higher learning beyond the secondary school level within 12 months following the accident. If, at the time of loss, none of the dependent children are eligible for the Education Benefit, the Company shall pay an additional amount of $2,500 to the designated beneficiary.

EYEGLASSES, CONTACT LENSES AND HEARING AIDS BENEFIT ($1,000)

If, due to injury, an insured requires and receives treatment by a physician, which results in the purchase of eyeglasses, contact lenses or hearing aids within 12 months of the date of the accident, when none of which were previously required or worn, the Company will pay the reasonable and necessary expenses actually incurred.

FAMILY TRANSPORTATION BENEFIT ($15,000)

If an injury results in confinement as an inpatient in a hospital located at least 150 km from the insured's residence, and such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the Company will pay the expenses actually incurred by a member of the immediate family for hotel accommodation and transportation by the most direct route to the confined insured. If transportation occurs in a private vehicle, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

FUNERAL EXPENSE BENEFIT ($10,000)

If an injury results in loss of life, an additional amount is payable for funeral expenses actually incurred.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT ($15,000)

If an injury requires the use of a wheelchair to be ambulatory, the Company will pay the cost of alterations to the insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, subject to a maximum of $15,000 as the result of any one Accident.

HOME CARE BENEFIT

If an injury sustained, within 30 days of the date of the accident, by an Insured Person, who is the primary home care provider, wholly and continuously disables and prevents the Insured Person from performing the duties necessary to provide the basic needs of the Insured Person's Dependent Children and the Insured Person's principal occupation is their home care, the Company will pay a $50.00 daily benefit for such period of continuous disability not to exceed 60 days as the result of any one injury. Benefits under this part are payable only while the Insured Person is under the regular care and attendance of a Physician or surgeon.

IDENTIFICATION BENEFIT ($5,000)

If an injury results in loss of life, and requires body identification, the Company will pay the expenses actually incurred by a member of the immediate family for lodging, board and transportation by the most direct route, provided the body is located not less than 150 kilometres from the member of the immediate family's residence and the identification of the body is required by the police or a similar law enforcement agency. If transportation occurs in a private vehicle, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

REHABILITATION BENEFIT ($15,000)

If an injury requires that the insured undergo special training in order to be qualified to engage in a special occupation in which the insured would not have engaged except for such injury, the Company will pay the reasonable and necessary expenses incurred for such training within 3 years of the date of the accident, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

REPATRIATION BENEFIT ($15,000)

If an injury results in loss of life, the Company will pay the expense incurred for shipment of the body to the city of residence of the deceased.

SEAT BELT BENEFIT

If an injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the principal sum will be increased by 10% if, at the time of the accident, the insured was driving or riding in a vehicle and wearing a properly fastened seat belt.

SPOUSAL RETRAINING BENEFIT ($15,000)

If an injury results in loss of life, the Company will reimburse the spouse for the reasonable and necessary expenses actually incurred for a formal occupational training program in order to become qualified for active employment in an occupation in which the spouse would not otherwise have sufficient qualifications.

WAIVER OF PREMIUM BENEFIT

In the event of total disability and waiver of premium has been approved and accepted by the group life carrier, then premium under this plan will be waived until the earlier of: death, recovery, attainment of age 65 or the date the policy is cancelled.

LIMITED AIR TRAVEL COVERAGE

Coverage includes injury sustained in consequence of riding as a passenger and not as a pilot or member of the crew, in; boarding or alighting from; being struck by; or making a forced landing with or from:

(a) any aircraft having a current and valid airworthiness certificate and which is operated by a person holding a current and valid pilot's license of a rating authorizing him to pilot such aircraft, or
(b) any transport-type aircraft operated by the Canadian Armed Forces or by the similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world, provided the aircraft is not being used for test or experimental purposes.

Notwithstanding (a) and (b) above, coverage excludes injury sustained while and in consequence of riding as a passenger, pilot, operator or member of the crew, in or on; boarding or alighting from; being struck by; or making a forced landing with or from any aircraft owned, operated or leased by the policyholder.

TERMINATION OF INSURANCE OF AN INSURED

Coverage will terminate immediately on the earliest of: (a) the policy termination date; (b) the premium due date if the Policyholder fails to pay the insured's premium, except as a result of an inadvertent error; (c) the premium due date coinciding with or immediately following the date an insured attains age 70; (d) the premium due date next following the date an insured becomes ineligible for coverage, except as provided under the Continuation of Coverage.

WHEN DOES THIS INSURANCE NOT APPLY?

- declared or undeclared war or any act thereof;
- active full-time service in the armed forces of any country;
- suicide or any attempt thereat or intentionally self-inflicted injury, regardless of any impairment, illness or state of mind;
- injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in the Limited Air Travel Coverage.
- Physical or mental illness or disease or treatment for the illness or disease.

BENEFICIARY

Indemnity payable in the event of the loss of life of an insured is payable in accordance with the beneficiary designation in effect under the policyholder's current Basic Group Life Insurance policy. Unless otherwise indicated and if there is no such designation, the indemnity is payable to the estate of the insured. All other indemnities are payable to the insured, with the exception of indemnities payable under the following parts:

Bereavement Benefit	Funeral Expense Benefit
Day Care Benefit	Identification Benefit
Education Benefit	Repatriation Benefit
Family Transportation Benefit	Spousal Retraining Benefit

In the situation where the policy replaces an existing policy issued to the policyholder, the designation recorded under the replaced policy will be deemed to be valid and of full force and effect under this policy until changed in writing by the insured.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

This summary is for information purposes only. For further details, refer to the Master Policy which is on file with the policyholder. The Master Policy sets forth in detail the terms and conditions of the plan and all rights and obligations are determined in accordance with the Master Policy issued by iA Special Markets, a division of Industrial Alliance Insurance and Financial Services Inc., not this summary.

Underwritten by:
Industrial Alliance Insurance and Financial Services Inc.
400 – 988 Broadway West, PO Box 5900
Vancouver, British Columbia, V6B 5H6
Toll Free: 1-800-266-5667

BASIC GROUP CRITICAL ILLNESS INSURANCE

INSURANCE BENEFITS SUMMARY

*This Insurance Benefits Summary is designed to outline the benefits for which you are eligible under Group Policy no. 100005769 issued to The Roman Catholic Archbishop of Vancouver by Industrial Alliance Insurance and Financial Services Inc. (the **Company**) which is available to you upon request. This Group Policy contains a provision removing or restricting the right of the Insured Person to designate persons to whom or for whose benefit insurance money is payable. In the event of any variation between the group insurance certificate, this document and the provisions of the Group Policy, the latter will prevail. All rights with respect to the benefits of an Insured Employee will be governed solely by the Group Policy which may be amended from time to time.*

PLAN DESCRIPTION

Covered Condition Benefit

If you are diagnosed by a Specialist with a Covered Condition while your Basic Group Critical Illness Insurance is in force and survive for 30 days following the Date of Diagnosis or such longer period as described in certain Covered Conditions, the Company will pay you the Basic Group Critical Illness Insurance Benefit Amount in force (the **Covered Condition Benefit**), subject to the terms and conditions of the Group Policy. The Date of Diagnosis must be later than the effective date or latest reinstatement date of your coverage. If you die before the approved Covered Condition Benefit is paid, the Covered Condition Benefit will be paid to your estate. In the event you receive a simultaneous Diagnosis of multiple Covered Conditions, the Company will pay the Covered Condition Benefit for one Covered Condition only. The Covered Condition for which the Covered Condition Benefit is paid will be the Covered Condition which first appears in the lowest Multiple Event Coverage Benefit grouping (**MEC Grouping**) shown in the **Multiple Event Coverage Benefit** section, starting with MEC Grouping Group 1.

Cancer Recurrence Benefit

If you receive a Diagnosis of Cancer under the Group Policy, and thereafter you are diagnosed with Cancer again only as described below, the Company will pay you the Benefit Amount in force (the **Cancer Recurrence Benefit**) subject to the terms and conditions of the Group Policy. **Cancer Recurrence** means you receive a subsequent Diagnosis of Cancer, provided that:

a) more than 60 months have passed between the previous Cancer Date of Diagnosis and the date of the subsequent Diagnosis;
b) you have not received any treatment relating directly or indirectly to the previous cancer within a continuous 60-month period prior to the subsequent Diagnosis;
c) you do not have any new signs, symptoms or deliberate or incidental findings, during a continuous 60-month period prior to the subsequent Diagnosis, for which you sought medical investigation, consultation to investigate and/or diagnose, Diagnosis, treatment, care, medication or medical advice, or for which there were symptoms that would have caused an individual to seek the same relating to a Diagnosis of any cancer covered or excluded under the Group Policy; and
d) both the first and subsequent diagnoses are made subsequent to the effective date of your coverage under the Group Policy and prior to the termination date of your coverage under the Group Policy.

AdvanceCare Benefit

If you are diagnosed by a Specialist with an AdvanceCare Benefit Condition while your Basic Group Critical Illness Insurance is in force, the Company will pay you a benefit equivalent to 10% of your Benefit Amount in force (the **AdvanceCare Benefit**), subject to the terms and conditions of the Group Policy. The Date of Diagnosis must be later than the effective date or latest reinstatement date of your coverage. If you die before the approved AdvanceCare Benefit is paid, the AdvanceCare Benefit will be paid to your estate. The AdvanceCare Benefit is a one-time benefit for which the Company will pay for one AdvanceCare Benefit Condition only. Payment of the AdvanceCare Benefit will not affect the amount of benefit payment under a Covered Condition Benefit or a Multiple Event Coverage Benefit. Your Basic Group Critical Illness Insurance will continue in force during the adjudication of an AdvanceCare Benefit and following the payment of an AdvanceCare Benefit, providing premiums continue to be paid as required.

Multiple Event Coverage Benefit

If you receive a Covered Condition Benefit under the Group Policy, and thereafter you are diagnosed with a different Covered Condition in a different Multiple Event Coverage Benefit grouping (**MEC Grouping**), the Company will pay you the Basic Group Critical Illness Insurance Benefit Amount in force (the **Multiple Event Coverage Benefit**), subject to the terms and conditions of the Group Policy. You must survive for 30 days following the Date of Diagnosis or such longer survival period as described in certain Covered Conditions to qualify for this benefit. If you die before the approved Multiple Event Coverage Benefit is paid, the Multiple Event Coverage Benefit will be paid to your estate.

MEC Grouping	Covered Condition
Group 1	Cancer
Group 2	Aortic Surgery, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement or Repair, Stroke
Group 3	Bacterial Meningitis, Benign Brain Tumour, Coma, Dementia including Alzheimer's Disease, Loss of Independent Existence, Loss of Speech, Motor Neuron Disease, Multiple Sclerosis, Paralysis, Parkinson's Disease and Specified Atypical Parkinsonian Disorders, Stroke
Group 4	Aplastic Anemia, Kidney Failure, Major Organ Failure on Waiting List, Major Organ Transplant
Group 5	Blindness
Group 6	Deafness
Group 7	Severe Burns
Group 8	Loss of Limbs
Group 9	Occupational HIV Infection

Limitations

a) **Cancer**

You will not be entitled to a Covered Condition Benefit for Cancer if, within the first 90 days following the issue date of your Basic Group Critical Illness Insurance coverage, you have a Diagnosis of Cancer, or have any signs, symptoms or investigations leading to the Diagnosis of Cancer, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If you continue to satisfy the eligibility provisions for coverage under the Group Policy, Basic Group Critical Illness Insurance will remain in force but Cancer in MEC Grouping 1 will no longer be considered a Covered Condition for you.

b) **Benign Brain Tumour**

You will not be entitled to a Covered Condition Benefit for Benign Brain Tumour if, within the first 90 days following the issue date of your Basic Group Critical Illness Insurance coverage, you have a Diagnosis of Benign Brain Tumour, or have any signs, symptoms or investigations leading to the Diagnosis of Benign Brain Tumour, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If you continue to satisfy the eligibility provisions for coverage under the Group Policy, Basic Group Critical Illness Insurance will remain in force but Benign Brain Tumour and all Covered Conditions in MEC Grouping 3 will no longer be considered Covered Conditions for you.

c) **Multiple Sclerosis**

You will not be entitled to a Covered Condition Benefit for Multiple Sclerosis if, within the first year following the issue date of your Basic Group Critical Illness Insurance coverage, you have a Diagnosis of Multiple Sclerosis, or have any signs, symptoms or investigations leading to the Diagnosis of Multiple Sclerosis, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If you continue to satisfy the eligibility provisions for coverage under the Group Policy, Basic Group Critical Illness Insurance will remain in force but Multiple Sclerosis and all Covered Conditions in MEC Grouping 3 will no longer be considered Covered Conditions for you.

d) **Parkinson's Disease and Specified Atypical Parkinsonian Disorders**

You will not be entitled to a Covered Condition Benefit for Parkinson's Disease and Specified Atypical Parkinsonian Disorders if, within the first year following the issue date of your Basic Group Critical Illness Insurance coverage, you have a Diagnosis of Parkinson's Disease and Specified Atypical Parkinsonian Disorders, or have any signs, symptoms or investigations leading to the Diagnosis of Parkinson's Disease and Specified Atypical Parkinsonian Disorders, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If you continue to satisfy the eligibility provisions for coverage under the Group Policy, Basic Group Critical Illness Insurance will remain in force but Parkinson's Disease and Specified Atypical Parkinsonian Disorders, and all Covered Conditions in MEC Grouping 3 will no longer be considered Covered Conditions for you.

e) **AdvanceCare Benefit**

You will not be entitled to an AdvanceCare Benefit for Early Stage Cancer if, within the first 90 days following the issue date of your Basic Group Critical Illness Insurance coverage, you have a Diagnosis of Early Stage Cancer, or have any signs, symptoms or investigations leading to the Diagnosis of Early Stage Cancer, regardless of when the Diagnosis is made. In the event of any such Diagnosis, Basic Group Critical Illness Insurance will remain in force but Early Stage Cancer will be removed as an AdvanceCare Benefit Condition for you.

Exclusions

In addition to the exclusions included within the definition of certain Covered Conditions, the following exclusions also apply.

No benefit will be paid if a Covered Condition or AdvanceCare Benefit Condition results directly or indirectly from any one or more of the following:

a) attempted suicide;
b) taking poison or inhaling gas, whether voluntarily or involuntarily, not connected with your employment;
c) taking any drug other than as prescribed by a licensed physician;
d) participation in a criminal act or any attempt to commit a criminal offense, including but not limited to operating a motor vehicle while the concentration of alcohol in 100 millilitres of your blood exceeds 80 milligrams;
e) intentionally self-inflicted injury, regardless of any impairment, illness, or state of mind.

In addition, no benefit will be paid if you suffer Blindness, Coma, Deafness, Loss of Limbs, Paralysis, Severe Burns or Stroke as a result, directly or indirectly, from amateur or professional boxing, bungee jumping, B.A.S.E. jumping, cliff diving, mountain climbing, motor vehicle racing or speed competition on land and/or water, parachuting or underwater activities, including scuba diving and snuba diving.

DEFINITIONS

POLICY DEFINITIONS

AdvanceCare Benefit Conditions are medical conditions for which an AdvanceCare Benefit is paid under the Group Policy. These are Coronary Angioplasty or Early Stage Cancer as defined in this document.

Benefit Amount means the amount of Basic Group Critical Illness Insurance for which an Insured Person is covered.

Covered Conditions are Aortic Surgery, Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Blindness, Cancer, Coma, Coronary Artery Bypass Surgery, Deafness, Dementia including Alzheimer's Disease, Heart Attack, Heart Valve Replacement or Repair, Kidney Failure, Loss of Independent Existence, Loss of Limbs, Loss of Speech, Major Organ Failure on Waiting List, Major Organ Transplant, Motor Neuron Disease, Multiple Sclerosis, Occupational HIV Infection, Paralysis, Parkinson's Disease and Specified Atypical Parkinsonian Disorders, Severe Burns and Stroke, as defined in the section titled *Definitions of Covered Conditions*.

Date of Diagnosis means the date on which a Specialist diagnoses the Insured Person with one of the Covered Conditions, with Cancer Recurrence, or with one of the AdvanceCare Benefit Conditions.

Diagnosis means the certified Diagnosis of the Insured Person with a Covered Condition, with Cancer Recurrence or with one of the AdvanceCare Benefit Conditions by a Specialist.

Employee means an employee (you) as defined in the Group Policy.

Insured Employee means an Insured Person (you) who is an eligible Employee.

Insured Person means an Employee who is insured under the Group Policy.

Specialist means a licensed medical practitioner who

- has been trained in the specific area of medicine relevant to the Covered Condition or AdvanceCare Benefit Condition for which a benefit is being claimed;
- has been certified by a specialty examining board; and
- is currently practicing in their area of specialty in Canada or the United States of America.

Specialist includes but is not limited to: cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The Specialist and any medical professional performing any tests or examinations required to satisfy the Covered Condition requirements must not be the Insured Person, a relative or business associate of the Insured Person.

In the absence or unavailability of a Specialist, and as approved by the Company, a Covered Condition or AdvanceCare Benefit Condition may be diagnosed by a qualified medical practitioner practicing in Canada or the United States of America.

DEFINITIONS OF COVERED CONDITIONS

Aortic Surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The Surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this condition for

- *Angioplasty;*
- *Intra-arterial procedures;*
- *Percutaneous trans-catheter procedures; or*
- *Non-surgical procedures.*

Aplastic Anemia means a definite Diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- Marrow stimulating agents;
- Immunosuppressive agents; or
- Bone marrow transplantation.

The Diagnosis of Aplastic Anemia must be made by a Specialist.

Bacterial Meningitis means a definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing the presence of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The Bacterial Meningitis must result in objective neurological deficits persisting for at least 90 days from the Date of Diagnosis.

The Diagnosis of Bacterial Meningitis must be made by a Specialist.

For purposes of the Group Policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable under this condition for viral meningitis.

Benign Brain Tumour means a definite Diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause Irreversible objective neurological deficit(s).

These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location, and timing with the neurological deficits.

The Diagnosis of Benign Brain Tumour must be made by a Specialist.

For purposes of the Group Policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions: No benefit will be payable under this condition for:

- *Pituitary adenomas less than 10 mm;*
- *Vascular malformations;*
- *Cholesteatomas; or*
- *Infectious or inflammatory tumours.*

90-Day Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the Issue Date of an Insured Person's coverage, or the last reinstatement date of an Insured Person's coverage, such Insured Person has any of the following:

- *Signs, symptoms, or investigations that lead to a Diagnosis of Benign Brain Tumour (covered or excluded under the Group Policy), regardless of when the Diagnosis is made; or*
- *A Diagnosis of Benign Brain Tumour (covered or not covered under the Group Policy).*

Medical Information about the Diagnosis and any signs, symptoms, or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Benign Brain Tumour or any critical illness caused by any Benign Brain Tumour or its treatment.

Blindness means a definite Diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

- the corrected visual acuity being 20/200 or less in both eyes; or
- the field of vision being less than 20 degrees in both eyes.

The Diagnosis of Blindness must be made by a Specialist.

Cancer means the definite Diagnosis of a malignant tumour. This tumour must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

The Diagnosis of Cancer must be made by a Specialist and must be confirmed by a pathology report.

For purposes of the Group Policy:

- T1a or T1b prostate cancer means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.
- The term gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1 means:

- Gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm2, or 50 per HPF; or
- Small intestinal, esophageal, colorectal, mesenteric and peritoneal GISTs that are less than or equal to 5 cm in greatest dimension with 5 or fewer mitoses per 5 mm2, or 50 per HPF;

- The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 1 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.
- The term Rai stage 0 is as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219,1975.

Exclusions: No benefit will be payable under this Covered Condition for the following:

- *Lesions described as benign, non-invasive, pre-malignant, of low and/or uncertain malignant potential, borderline, carcinoma in situ, or tumors classified as Tis or Ta;*
- *Malignant melanoma of skin that is less than or equal to 1.0mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;*
- *Any non-melanoma skin cancer, without lymph node or distant metastasis. This includes but is not limited to, cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;*
- *Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;*
- *Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0cm in greatest dimension and classified as T1, without lymph node or distant metastasis;*
- *Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;*
- *Gastro-intestinal stromal tumours classified as AJCC Stage 1;*
- *Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormonal oversecretion by the tumour; or*
- *Thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.*

90-Day Exclusion : No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the Issue Date of an Insured Person's coverage, or the last reinstatement date of an Insured Person's coverage, the Insured Person has any of the following:

- *Signs, symptoms or investigations leading directly or indirectly to a diagnosis of any cancer (covered or not covered under the Group Policy), regardless of when the diagnosis is made; or*
- *A diagnosis of any cancer (covered or not covered under the Group Policy).*

Medical Information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Cancer or any critical illness caused by any cancer or its treatment.

Coma means a definite Diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours and for which period the Glasgow coma score must be 4 or less. The Diagnosis of Coma must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for:

- *A medically induced coma; or,*
- *A coma which results directly from alcohol or drug use; or,*
- *A diagnosis of brain death.*

Coronary Artery Bypass Surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The Surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for:

- *Angioplasty;*
- *Intra-arterial procedures;*
- *Percutaneous trans-catheter procedures; or,*
- *Non-surgical procedures.*

Deafness means a definite Diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

The Diagnosis of Deafness must be made by a Specialist.

Dementia, including Alzheimer's Disease means a definite Diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- Aphasia (a disorder of speech);
- Apraxia (difficulty performing familiar tasks);
- Agnosia (difficulty recognizing objects); or
- Disturbance in executive functioning (e.g. Inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behavior), which is affecting daily life.

The Insured Person must exhibit:

- Dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- Evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6-month period.

The Diagnosis of Dementia, including Alzheimer's Disease must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for affective or schizophrenic disorders, or delirium.

For purposes of the Group Policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189.

Heart Attack (acute myocardial infarction) means a definite Diagnosis of the death of heart muscle due to obstruction of blood flow that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

- Heart attack symptoms;
- New electrocardiogram (ECG) changes consistent with a heart attack;
- Development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The Diagnosis of Heart Attack must be made by a Specialist.

Exclusions: No benefit will be payable under this condition for:

- *ECG changes suggestive of a prior myocardial infarction;*
- *Other acute coronary syndromes, including angina pectoris and unstable angina; or*
- *Elevated cardiac biomarkers and/or symptoms that are due to medical procedures or diagnoses other than heart attack.*

Heart Valve Replacement or Repair means the undergoing of Surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The Surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for

- *Angioplasty;*
- *Inter-arterial procedures;*
- *Percutaneous trans-catheter procedures; or*
- *Non-surgical procedures.*

Kidney Failure means a definite Diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

The Diagnosis of Kidney Failure must be made by a Specialist.

Loss of Independent Existence means a definite Diagnosis of the total inability, due to disease or injury, to perform independently, with or without the aid of assistive devices, at least 3 of 6 Activities of Daily Living listed below for a continuous period of at least 90 days with no reasonable chance of recovery. The Diagnosis must be made by a physician and supported by an independent home care assessment made by an occupational therapist or equivalent.

Activities of Daily Living are as follows:

Bathing: washing oneself in a bathtub, shower or by sponge bath;

Dressing: putting on and removing necessary clothing, braces, artificial limbs or other surgical appliances;

Toileting: getting on and off the toilet and maintaining personal hygiene;

Bladder and bowel continence: managing one's bladder and bowel function with or without protective undergarments or surgical appliances so that hygiene is maintained;

Transferring: moving in and out of a bed, chair or wheelchair;

Feeding: consuming food or drink that already has been prepared and made available.

No additional survival period is required once the conditions described above are satisfied.

Loss of Limbs means a definite Diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

The Diagnosis of Loss of Limbs must be made by a Specialist.

Loss of Speech means a definite Diagnosis of the total and irreversible loss of the ability to speak as a result of physical injury or disease, for a period of at least 180 days.

The Diagnosis of Loss of Speech must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for all psychiatric related causes.

Major Organ Failure on Waiting List means a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the Insured Person must become enrolled as the recipient in a recognized transplant center in Canada or the United States of America that performs the required form of transplant surgery. For the purpose of the survival period, the Date of Diagnosis is the date of the Insured Person's enrolment in the transplant centre. The Diagnosis of the major organ failure must be made by a Specialist.

Major Organ Transplant means a definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

The Diagnosis of the major organ failure must be made by a Specialist.

Motor Neuron Disease means a definite Diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions.

The Diagnosis of Motor Neuron Disease must be made by a Specialist.

Multiple Sclerosis means a definite Diagnosis of at least one of the following:

- Two or more separate clinical attacks, confirmed by a magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;

- A single attack, with objective neurological deficits lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or,
- A single attack, confirmed by repeated MRI of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

The Diagnosis of Multiple Sclerosis must be made by a Specialist.

For purposes of the Group Policy, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable for the following:

- *Solitary sclerosis;*
- *Clinically isolated syndrome;*
- *Radiologically isolated syndrome;*
- *Neuromyelitis optica spectrum disorders; or*
- *Suspected multiple sclerosis or probable multiple sclerosis.*

1-Year Exclusion: No benefit will be payable under this Covered Condition if, within the first year following the later of the Issue Date of an Insured Person's coverage or the last reinstatement date of an Insured Person's coverage, the Insured Person has any of the following:

- *Signs, symptoms or investigations leading directly or indirectly to a diagnosis of multiple sclerosis (covered or not covered under the Group Policy) regardless of when the diagnosis is made; or*
- *A diagnosis of multiple sclerosis (covered or not covered under the Group Policy).*

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Multiple Sclerosis or, any critical illness caused by multiple sclerosis or its treatment.

Occupational HIV Infection means a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the effective date of such Insured Person's insurance coverage.

Payment under this condition requires satisfaction of all of the following:

- The accidental injury must be reported to the Company within 14 days of the accidental injury;
- A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
- A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America;
- The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

The Diagnosis of Occupational HIV Infection must be made by a Specialist.

Exclusion: No benefit will be payable under this condition if:

- *the Insured Person has elected not to take any available licensed vaccine offering protection against HIV;*
- *a licensed cure for HIV infection has become available prior to the accidental injury; or,*
- *HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.*

Paralysis means a definite Diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

The Diagnosis of Paralysis must be made by a Specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders means a definite Diagnosis of primary Parkinson's Disease, a permanent neurological condition which must be characterized by bradykinesia (slowness of movement) and at least one of the following: muscular rigidity or rest tremor. The Insured Person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease. Specified Atypical Parkinsonian Disorders are defined as a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The Diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a Specialist.

1-year Exclusion: No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the later of the Issue Date or the latest reinstatement date of an Insured Person's coverage, such Insured Person has any of the following:

- *Signs, symptoms or investigations that lead to a Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the Diagnosis is made; or*
- *A Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.*

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

No benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of parkinsonism.

Severe Burns means a definite Diagnosis of third-degree burns over at least 20% of the body surface.

The Diagnosis of Severe Burns must be made by a Specialist.

Stroke (cerebrovascular accident resulting in persistent neurological deficits) means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis, haemorrhage, or embolism with:

- Acute onset of new neurological symptoms, and
- New objective neurological deficits on clinical examination;

persisting for more than 30 days following the Date of Diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing showing changes that are consistent in character, location, and timing with the new neurological deficits.

The Diagnosis of Stroke must be made by a Specialist.

For purposes of the Group Policy, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia, (difficulty with speech) dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable under this covered condition for:

- *Transient Ischaemic Attacks;*
- *Intracerebral vascular events due to trauma;*
- *Ischaemic disorders of the vestibular syndrome;*
- *Death of tissue of the optic nerve or retina without total loss of vision of that eye; or*
- *Lacunar infarcts which do not meet the definition of stroke as described above.*

DEFINITIONS OF ADVANCECARE BENEFIT CONDITIONS

Coronary Angioplasty means the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a Specialist.

Early Stage Cancer refers to one of the following conditions:

- Malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;
- Gastrointestinal stromal tumours classified as AJCC Stage 1;
- Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormone oversecretion by the tumour;
- Thymomas (Stage 1), confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus; or
- Ductal Carcinoma in situ of the Breast

The Diagnosis of an Early Stage Cancer must be made by a Specialist.

CLAIMS AT TUGO

As an insured person under a Company critical illness insurance plan, you are eligible to access **Claims at** TuGo. **Claims at** TuGo is a service that provides assistance in obtaining specialized, private medical treatment at claim time. **Claims at** TuGo coordinates medical appointments and procedures with specialists and surgeons at special pricing discounts.

For assistance in accessing this service, please visit www.tugo.com/tms.

Note that utilization fees may apply.

GENERAL PROVISIONS

Termination of Your Insurance

Your Basic Group Critical Illness Insurance will terminate automatically on the earliest of the following dates:

a) the termination date of the Group Policy;
b) the date of your death;
c) the date on which your employment terminates or changes so that you cease to be eligible for insurance under the Group Policy;
d) when you are under age 65 and reside in Québec, the date on which you are no longer covered under a private drug plan provided by the Policyholder, as required by the Québec Act respecting prescription drug insurance;
e) the end of the month coincident with or following the date the Company receives written notice from the Policyholder requesting cancellation of the Basic Group Critical Illness Insurance coverage;
f) the date on which a leave of absence has expired, and you are not actively at work;
g) when you are not actively at work, as a result of a disability and you are under age 63 when such disability related absence from work commences, your Basic Group Critical Illness Insurance will terminate on the date you attain age 65, unless you return to full-time active employment before age 65;
h) when you are not actively at work as a result of a disability and you are age 63 or older but less than age 80 when such disability related absence from work commences, your Basic Group Critical Illness Insurance will terminate on the date of completion of 24 consecutive months of disability related absence from work unless you return to full-time employment before 24 months of disability have expired; and
i) when you are not actively at work as a result of a disability and you are age 80 or older when such disability related absence from work commences, your Basic Group Critical Illness Insurance will terminate on the date of completion of 12 consecutive months of disability related absence from work.

Important note regarding termination of your coverage:

You must advise our office in writing once you, your Insured Spouse, and/or your Insured Dependent Child(ren) are no longer eligible for coverage under the Group Policy, if applicable.

Depending on when the Company is advised, the premium payor may be eligible to receive a premium refund of up to 3 months, if applicable.

Conversion Privilege

If your Basic Group Critical Illness Insurance terminates as a result of ceasing to be eligible for insurance under the Group Policy and you have not received a Covered Condition Benefit nor an AdvanceCare Benefit from the Company, you may, before age 65 and without evidence of insurability, convert your terminated Basic Group Critical Illness Insurance to a separate critical illness policy (the **Converted Coverage**), issued by the Company subject to all of the following conditions:

a) the minimum amount of insurance in force with respect to the Insured Person on the date of termination must be $5,000;
b) the maximum amount of insurance under the Converted Coverage will be limited to the lesser amount of $100,000 and the amount of coverage in force with respect to the Insured Person on the date of termination;
c) the Insured Person must reside in Canada at the time of application and submit a completed application and the first premium to the Company within 31 days of the date of termination of such Insured Person's insurance;
d) the Converted Coverage will be of a type then issued by the Company providing term insurance to age 75;
e) the Converted Coverage will be issued without waiver of premium benefit, return of premium benefit, paid-up benefit or guaranteed increase benefit;
f) the premium rates for the Converted Coverage will be those then in effect for such policy;
g) the premium rates will be based on the Insured Person's gender, smoker status and age at the time of conversion; and
h) if a special provision, exclusion and/or limitation had been imposed on the Basic Group Critical Illness Insurance, then a comparable special provision, exclusion and/or limitation will be imposed on the Converted Coverage.

CLAIMS PROCEDURES

Before paying a benefit under the Group Policy, we will require our claims forms to be duly completed and sent to the Company's address below. Please call us toll-free at: 1.800.266.5667 to obtain the appropriate forms and for details on claims procedures.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act. Insurance Act means the applicable insurance legislation in the applicable provincial jurisdiction.

Note: All claims will be adjudicated according to the definition of the Covered Condition or the AdvanceCare Benefit Condition applicable at the time of Diagnosis.

QUESTIONS? WE'RE HERE TO HELP.

Contact a Client Service Specialist at:

1.800.266.5667 (toll free)
604.737.3802 (Vancouver)
SpecialMarkets@ia.ca
Monday to Friday 6:30 a.m. - 4:30 p.m. Pacific Time

Or write to:

iA Special Markets
Industrial Alliance Insurance and Financial Services Inc.
400-988 Broadway W PO Box 5900
Vancouver, BC V6B 5H6

Or visit our website at:

www.ia.ca

VOLUNTARY GROUP CRITICAL ILLNESS INSURANCE

INSURANCE BENEFITS SUMMARY

*This Insurance Benefits Summary is designed to outline the Voluntary Group Critical Illness Insurance benefits which are available to you (and your dependents, when insured) under Group Policy no. 100007862 issued to The Roman Catholic Archbishop of Vancouver by Industrial Alliance Insurance and Financial Services Inc. (**the Company**) which is available to you upon request. This Group Policy contains a provision removing or restricting the right of the Insured Person to designate persons to whom or for whose benefit insurance money is payable. In the event of any variation between the Group Insurance Certificate, this summary and the provisions of the Group Policy, the latter will prevail. All rights with respect to the benefits of an Insured Person will be governed solely by the Group Policy which may be amended from time to time.*

BENEFIT SCHEDULE

You, your Spouse and Dependent Children are insured for benefits indicated on your Group Insurance Certificate.

PLAN DESCRIPTION – EMPLOYEE OR SPOUSE COVERAGE

Covered Condition Benefit

If an Insured Employee or Insured Spouse is diagnosed by a Specialist with a Covered Condition while Voluntary Group Critical Illness Insurance is in force and survives for 30 days following the Date of Diagnosis or such longer period as described in certain Covered Conditions, the Company will pay such Insured Person the Voluntary Group Critical Illness Insurance Benefit Amount in force (the **Covered Condition Benefit**), subject to the terms and conditions of the Group Policy. The Date of Diagnosis must be later than the effective date of coverage. If the Insured Person dies before the approved Covered Condition Benefit is paid, the Covered Condition Benefit will be paid to the Insured Person's estate. In the event an Insured Person receives a simultaneous Diagnosis of multiple Covered Conditions, the Company will pay the Covered Condition Benefit for one Covered Condition only. The Covered Condition for which the Covered Condition Benefit is paid will be the Covered Condition which first appears in the lowest Multiple Event Coverage Benefit grouping (**MEC Grouping**) shown in the **Multiple Event Coverage Benefit** section, starting with MEC Grouping Group 1.

Cancer Recurrence Benefit

If an Insured Employee or Insured Spouse receives a Diagnosis of Cancer under the Group Policy, and thereafter the Insured Person is diagnosed with Cancer again only as described below, the Company will pay the Insured Person the Benefit Amount in force (the **Cancer Recurrence Benefit**) subject to the terms and conditions of the Group Policy. **Cancer Recurrence** means an Insured Person receives a subsequent Diagnosis of Cancer, provided that:

a) more than 60 months have passed between the previous Cancer Date of Diagnosis and the date of the subsequent Diagnosis;
b) the Insured Person has not received any treatment relating directly or indirectly to the previous cancer within a continuous 60-month period prior to the subsequent Diagnosis;
c) the Insured Person does not have any new signs, symptoms or deliberate or incidental findings, during a continuous 60-month period prior to the subsequent Diagnosis, for which they sought medical investigation, consultation to investigate and/or diagnose, Diagnosis, treatment, care, medication or medical advice, or for which there were symptoms that would have caused an individual to seek the same relating to a Diagnosis of any cancer covered or excluded under the Group Policy; and
d) both the first and subsequent diagnoses are made subsequent to the effective date of coverage under the Group Policy and prior to the termination date of coverage under the Group Policy.

AdvanceCare Benefit

If an Insured Employee or Insured Spouse is diagnosed by a Specialist with an AdvanceCare Benefit Condition while Voluntary Group Critical Illness Insurance is in force, the Company will pay such Insured Person a benefit equivalent to 10% of the Benefit Amount in force (the **AdvanceCare Benefit**), subject to the terms and conditions of the Group Policy. The Date of Diagnosis must be later than the effective date of coverage. If the Insured Person dies before the approved AdvanceCare Benefit is paid, the AdvanceCare Benefit will be paid to such Insured Person's estate. The AdvanceCare Benefit is a one-time benefit for which the Company will pay for one AdvanceCare Benefit Condition only.

Payment of the AdvanceCare Benefit will not affect the amount of benefit payment under a Covered Condition Benefit or a Multiple Event Coverage Benefit.

Voluntary Group Critical Illness Insurance will continue in force during the adjudication of an AdvanceCare Benefit and following the payment of an AdvanceCare Benefit, providing premiums continue to be paid as required.

Multiple Event Coverage Benefit

If an Insured Employee or Insured Spouse receives a Covered Condition Benefit under the Group Policy, and thereafter the Insured Person is diagnosed with a different Covered Condition in a different Multiple Event Coverage Benefit grouping (**MEC Grouping**), the Company will pay such Insured Person the Voluntary Group Critical Illness Insurance Benefit Amount in force (the **Multiple Event Coverage Benefit**), subject to the terms and conditions of the Group Policy. The Insured Person must survive for 30 days following the Date of Diagnosis or such longer survival period as described in certain Covered Conditions to qualify for this benefit. If an Insured Person dies before the approved Multiple Event Coverage Benefit is paid, the Multiple Event Coverage Benefit will be paid to such Insured Person's estate.

MEC Grouping	Covered Condition
Group 1	Cancer
Group 2	Aortic Surgery, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement or Repair, Stroke
Group 3	Bacterial Meningitis, Benign Brain Tumour, Coma, Dementia including Alzheimer's Disease, Loss of Independent Existence, Loss of Speech, Motor Neuron Disease, Multiple Sclerosis, Paralysis, Parkinson's Disease and Specified Atypical Parkinsonian Disorders, Stroke
Group 4	Aplastic Anemia, Kidney Failure, Major Organ Failure on Waiting List, Major Organ Transplant
Group 5	Blindness
Group 6	Deafness
Group 7	Severe Burns
Group 8	Loss of Limbs
Group 9	Occupational HIV Infection

Limitations

a) Cancer

An Insured Employee or Insured Spouse will not be entitled to a Covered Condition Benefit for Cancer if, within the first 90 days following the Issue Date of Voluntary Group Critical Illness Insurance coverage, such Insured Person has a Diagnosis of Cancer, or has any signs, symptoms or investigations leading to the Diagnosis of Cancer, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If the Insured Person continues to satisfy the eligibility provisions for coverage under the Group Policy, Voluntary Group Critical Illness Insurance will remain in force but Cancer in MEC Grouping 1 will no longer be considered a Covered Condition for such Insured Person.

b) Benign Brain Tumour

An Insured Employee or Insured Spouse will not be entitled to a Covered Condition Benefit for Benign Brain Tumour if, within the first 90 days following the Issue Date of Voluntary Group Critical Illness Insurance coverage, such Insured Person has a Diagnosis of Benign Brain Tumour, or has any signs, symptoms or investigations leading to the Diagnosis of Benign Brain Tumour, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If the Insured Person continues to satisfy the eligibility provisions for coverage under the Group Policy, Voluntary Group Critical Illness Insurance will remain in force but Benign Brain Tumour and all Covered Conditions in MEC Grouping 3 will no longer be considered Covered Conditions for such Insured Person.

c) Multiple Sclerosis

An Insured Employee or Insured Spouse will not be entitled to a Covered Condition Benefit for Multiple Sclerosis if, within the first year following the Issue Date of Voluntary Group Critical Illness Insurance coverage, such Insured Person has a Diagnosis of Multiple Sclerosis, or has any signs, symptoms or investigations leading to the Diagnosis of Multiple Sclerosis, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If the Insured Person continues to satisfy the eligibility provisions for coverage under the Group Policy, Voluntary Group Critical Illness Insurance will remain in force but Multiple Sclerosis and all Covered Conditions in MEC Grouping 3 will no longer be considered Covered Conditions for such Insured Person.

d) Parkinson's Disease and Specified Atypical Parkinsonian Disorders

An Insured Employee or Insured Spouse will not be entitled to a Covered Condition Benefit for Parkinson's Disease and Specified Atypical Parkinsonian Disorders if, within the first year following the Issue Date of Voluntary Group Critical Illness Insurance coverage, such Insured Person has a Diagnosis of Parkinson's Disease and Specified Atypical Parkinsonian Disorders, or has any signs, symptoms or investigations leading to the Diagnosis of Parkinson's Disease and Specified Atypical Parkinsonian Disorders, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If the Insured Person continues to satisfy the eligibility provisions for coverage under the Group Policy, Voluntary Group Critical Illness Insurance will remain in force but Parkinson's Disease and Specified Atypical Parkinsonian Disorders, and all Covered Conditions in MEC Grouping 3 will no longer be considered Covered Conditions for such Insured Person.

e) AdvanceCare Benefit

An Insured Employee or Insured Spouse will not be entitled to an AdvanceCare Benefit for Early Stage Cancer if, within the first 90 days following the Issue Date of Voluntary Group Critical Illness Insurance coverage, such Insured Person has a Diagnosis of Early Stage Cancer, or has any signs, symptoms or investigations leading to the Diagnosis of Early Stage Cancer, regardless of when the Diagnosis is made. In the event of any such Diagnosis, Voluntary Group Critical Illness Insurance will remain in force, but Early Stage Cancer will be removed as an AdvanceCare Benefit Condition for such Insured Person.

Exclusions

In addition to the exclusions included within the definition of certain Covered Conditions, the following exclusions also apply:

a) No benefit will be paid if a Covered Condition results from any Covered Condition or AdvanceCare Benefit Condition diagnosed prior to the effective date of an Insured Person's Voluntary Group Critical Illness Insurance;

b) No benefit will be paid if an AdvanceCare Benefit Condition results from any AdvanceCare Benefit Condition diagnosed prior to the effective date of an Insured Person's Voluntary Group Critical Illness Insurance;

c) No benefit will be paid if a Covered Condition or AdvanceCare Benefit Condition results directly or indirectly from any one or more of the following:
   i) attempted suicide;
   ii) taking any drug other than as prescribed by a licensed physician;
   iii) taking poison or inhaling gas, whether voluntarily or involuntarily, not connected with the Insured Person's employment;
   iv) war or full-time active service in the armed forces of any country;
   v) flying as a student pilot or flying as a privately licensed pilot for less than 25 hours or more than 400 hours per year;
   vi) participation in a criminal act or any attempt to commit a criminal offense, including but not limited to operating a motor vehicle while the concentration of alcohol in 100 millilitres of the Insured Person's blood exceeds 80 milligrams; or
   vii) intentionally self-inflicted injury, regardless of any impairment, illness, or state of mind.

d) with respect to Voluntary Group Critical Illness Insurance issued as a result of a Special Offer or New Employee Offer, in addition to the exclusions described above, no benefit will be paid if a Covered Condition or AdvanceCare Benefit Condition results directly or indirectly from a Pre-existing Condition. A **Pre-existing Condition** means any symptom, condition, disorder, illness, pre-disease or disease, or any mental, nervous or psychiatric condition or disorder for which any one of medical advice, treatment, service, prescribed medication, Diagnosis or consultation, including consultation to investigate and/or diagnose (where Diagnosis has not yet been made) was received by the Insured Person or would have been received by a prudent individual within the 24 months immediately preceding the effective date of such Insured Person's coverage. This exclusion applies for the 24 months following the effective date of the Insured Person's Voluntary Group Critical Illness Insurance coverage under the Special Offer or New Employee Offer.

   NOTE: Exclusion d) applicable to the Special Offer and New Employee Offer coverages only, will be removed with respect to an Insured Employee or Insured Spouse in the event that such Insured Person applies for additional Voluntary Group Critical Illness Insurance coverage which is subject to evidence of insurability and such coverage is approved by the Company.

In addition, no benefit will be paid if the Insured Person suffers Blindness, Coma, Deafness, Loss of Limbs, Paralysis, Severe Burns or Stroke as a result, directly or indirectly, from amateur or professional boxing, bungee jumping, B.A.S.E. jumping, cliff diving, mountain climbing, motor vehicle racing or speed competition on land and/or water, parachuting or underwater activities, including scuba diving and snuba diving.

Conversion Privilege

If the Voluntary Group Critical Illness Insurance of an Insured Employee or Insured Spouse terminates as a result of such Insured Person ceasing to be eligible for insurance under the Group Policy and the Insured Person has not received a Covered Condition Benefit nor an AdvanceCare Benefit from the Company, the Insured Person may, before their 65th birthday and without evidence of insurability, convert their terminated Voluntary Group Critical Illness Insurance to a separate critical illness policy (the **Converted Coverage**), issued by the Company subject to the following conditions:

a) the minimum amount of insurance in force with respect to the Insured Person on the date of termination must be $5,000;

b) the maximum amount of insurance under the Converted Coverage will be limited to the lesser amount of $100,000 and the amount of coverage in force with respect to the Insured Person on the date of termination;

c) the Insured Person must reside in Canada at the time of application and submit a completed application and the first premium to the Company within 31 days of the date of termination of such Insured Person's insurance;

d) the Converted Coverage will be of a type then issued by the Company providing term insurance to age 75;

e) the Converted Coverage will be issued without waiver of premium benefit, return of premium benefit, paid-up benefit or guaranteed increase benefit;

f) the premium rates for the Converted Policy will be those then in effect for such policy;

g) the premium rates will be based on the Insured Person's gender, smoker status and age at the time of conversion; and

h) if a special provision, exclusion and/or limitation had been imposed on the Voluntary Group Critical Illness Insurance, then a comparable special provision, exclusion and/or limitation will be imposed on the Converted Coverage.

Note: Insured Dependent Children are <u>not</u> eligible for the Conversion Privilege.

PLAN DESCRIPTION – DEPENDENT CHILD COVERAGE

Dependent Child Covered Condition Benefit

If an Insured Dependent Child is diagnosed by a Specialist with a Covered Condition while their Dependent Child Critical Illness Insurance is in force and survives for 30 days following the Date of Diagnosis or such longer period as described in certain Covered Conditions, the Company will pay to the Insured Employee the Benefit Amount in force with respect to such Insured Dependent Child (the **Dependent Child Covered Condition Benefit**), subject to the terms and conditions of the Group Policy. The Date of Diagnosis must be later than the effective date of coverage. If the Insured Dependent Child dies before the approved Dependent Child Covered Condition Benefit is paid, the Company will pay the Dependent Child Covered Condition Benefit to the Insured Employee.

The Company will pay the Dependent Child Covered Condition Benefit in respect of any Insured Dependent Child for one Covered Condition only.

Notwithstanding the foregoing, with respect to an Insured Dependent Child who is a natural child of the Insured Employee born on or after the effective date of Dependent Child Critical Illness Insurance coverage under the Group Policy:

a) if such Insured Dependent Child, while in the womb, is diagnosed by a Specialist with a Covered Condition, excluding Cancer, Benign Brain Tumour and Multiple Sclerosis, and such Insured Dependent Child survives for 30 days following the effective date of Dependent Child Critical Illness Insurance in respect of such Dependent Child, the Company will pay the Dependent Child Covered Condition Benefit in force to the Insured Employee;
b) if such Insured Dependent Child, while in the womb, is diagnosed by a Specialist with Cancer, Benign Brain Tumour or Multiple Sclerosis, the terms described in Limitations section a) below will apply.

In addition, with respect to an Insured Dependent Child who is a natural child of the Insured Employee born in the first 10 months following the effective date of coverage under the Group Policy, the terms described in Limitations section b) below will apply.

Limitations

a) <u>Cancer, Benign Brain Tumour and Multiple Sclerosis</u>

An Insured Dependent Child will not be entitled to a Dependent Child Covered Condition Benefit for Cancer, Benign Brain Tumour or Multiple Sclerosis and coverage will be void if such Dependent Child has a Diagnosis of Cancer, Benign Brain Tumour or Multiple Sclerosis, or has any signs, symptoms or investigations leading to such Diagnosis, regardless of when the Diagnosis is made, which are initiated within the first 90 days (with respect to Cancer or Benign Brain Tumour) or within the first year (with respect to Multiple Sclerosis) following the effective date of an Insured Dependent Child's coverage.
In addition, an Insured Dependent Child who is your natural child born on or after the effective date of coverage of such Employee's Dependent Child Critical Illness Insurance coverage is not entitled to a Dependent Child Covered Condition Benefit for Cancer, Benign Brain Tumour or Multiple Sclerosis, and coverage will be void if Cancer, Benign Brain Tumour or Multiple Sclerosis was diagnosed while such Dependent Child was in the womb. In the event that such Insured Dependent Child is the only Insured Dependent Child of the Employee, then applicable premiums paid for Dependent Child Critical Illness Insurance will be refunded.

b) <u>All Covered Conditions excluding Cancer, Benign Brain Tumour and Multiple Sclerosis</u>

An Insured Dependent Child who is a natural child of an Insured Employee born in the 10 month period immediately following the effective date of such Employee's Dependent Child Critical Illness Insurance coverage, will not be entitled to a Dependent Child Covered Condition Benefit if, within 30 days of birth such Insured Dependent Child has any of the following:

1. a Diagnosis of a Covered Condition or
2. the child's parent or physician notices or becomes aware of any sign, symptom, condition or medical problem that leads to a Diagnosis of a Covered Condition at any time in the future.

In the event of any such Diagnosis with respect to the Insured Dependent Child, of a Covered Condition other than Cancer, Benign Brain Tumour or Multiple Sclerosis, the Dependent Child Critical Illness Insurance will remain in force but the applicable diagnosed Covered Condition will no longer be considered a Covered Condition for such Dependent Child.

Exclusions

In addition to the exclusions included within the definitions of certain Covered Conditions, the following exclusions will also apply.

No benefit will be paid if a Dependent Child's Covered Condition results directly or indirectly from any one or more of the following:

a) any Covered Condition diagnosed prior to the effective date of such child's Dependent Child Critical Illness Insurance coverage.
b) attempted suicide;
c) taking any drug other than as prescribed by a licensed physician;
d) taking poison or inhaling gas, whether voluntarily or involuntarily, not connected with the employment of the Insured Dependent Child;
e) war or full-time active service in the armed forces of any country;
f) participation in a criminal act or any attempt to commit a criminal offense, including, but not limited to, operating a motor vehicle while the concentration of alcohol in 100 millilitres of the Insured Dependent Child's blood exceeds 80 milligrams;
g) flying as a student pilot or flying as a privately licensed pilot for less than 25 hours or more than 400 hours per year;
h) intentionally self-inflicted injury, regardless of any impairment, illness, or state of mind.

In addition, no benefit will be paid if the Insured Dependent Child suffers Blindness, Coma, Deafness, Loss of Limbs, Paralysis, Severe Burns or Stroke, as a result, directly or indirectly, from amateur or professional boxing, bungee jumping, B.A.S.E. jumping, cliff diving, mountain climbing, motor vehicle racing or speed competition on land and/or water, parachuting or underwater activities, including scuba diving and snuba diving.

With respect to Dependent Child Critical Illness Insurance issued as a result of a Special Offer or New Employee Offer, in addition to the exclusions described above, no benefit will be paid if a Covered Condition results directly or indirectly from a Pre-existing Condition. A **Pre-existing Condition** means any symptom, condition, disorder, illness, pre-disease or disease, or any mental, nervous or psychiatric condition or disorder for which any one of medical

advice, treatment, service, prescribed medication, diagnosis or consultation, including consultation to investigate and/or diagnose (where diagnosis has not yet been made) was received by the Insured Dependent Child or would have been received by a prudent individual within the 24 months immediately preceding the effective date of an Insured Dependent Child's coverage. This exclusion applies for the 24 months following the effective date of such Insured Dependent Child's coverage. This exclusion does not apply to a Dependent Child who is a natural child of an Insured Employee born on or after the effective date of such Employee's Dependent Child Critical Illness Insurance coverage.

DEFINITIONS

POLICY DEFINITIONS

AdvanceCare Benefit Conditions are medical conditions for which an AdvanceCare Benefit is paid under the Group Policy with respect to an Insured Employee or Insured Spouse. These are Coronary Angioplasty or Early Stage Cancer as defined in this document.

Benefit Amount means the amount of Voluntary Group Critical Illness Insurance or Dependent Child Critical Illness Insurance for which an Insured Person has been approved by the Company, as indicated in the Group Insurance Certificate issued to you.

Covered Conditions with respect to an Insured Employee, Insured Spouse or Insured Dependent Child are Aortic Surgery, Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Blindness, Cancer, Coma, Coronary Artery Bypass Surgery, Deafness, Heart Attack, Heart Valve Replacement or Repair, Kidney Failure, Loss of Limbs, Loss of Speech, Major Organ Failure on Waiting List, Major Organ Transplant, Motor Neuron Disease, Multiple Sclerosis, Occupational HIV Infection, Paralysis, Severe Burns and Stroke, as defined in the section titled *Definitions of Covered Conditions – All Insured Persons*.

Covered Conditions with respect to an Insured Employee and Insured Spouse only are Dementia including Alzheimer's Disease, Loss of Independent Existence, and Parkinson's Disease and Specified Atypical Parkinsonian Disorders, as defined in the section titled *Definitions of Covered Conditions – Employees and Spouses Only*.

Covered Conditions with respect to an Insured Dependent Child only are Cerebral Palsy, Congenital Heart Disease, Cystic Fibrosis, Down Syndrome, Muscular Dystrophy and Type 1 Diabetes, as defined in the section titled *Definitions of Covered Conditions – Dependent Children Only*.

Date of Diagnosis means the date on which a Specialist diagnoses the Insured Person with one of the Covered Conditions, with Cancer Recurrence, or with one of the AdvanceCare Benefit Conditions.

Dependent Child means your natural child, step-child or legally adopted child who is under 21 years of age, unmarried and receives full parental support and maintenance; or 21 years of age or over but under 25 years of age, unmarried and receives full parental support and maintenance for reason of full-time attendance at a recognized school, college or university.

Diagnosis means the certified Diagnosis of the Insured Person with a Covered Condition, with Cancer Recurrence or with one of the AdvanceCare Benefit Conditions by a Specialist.

Employee means an employee (you) as defined in the Group Policy.

Insured Dependent Child means an Insured Person who is your Dependent Child.

Insured Employee means an Insured Person (you) who is an eligible Employee.

Insured Person means a person who is eligible and insured under the Group Policy.

Insured Spouse means an Insured Person who is a Spouse.

New Employee Offer (when applicable) means Voluntary Group Critical Illness Insurance and Dependent Child Critical Illness Insurance available to a new Employee, their Spouse and/or Dependent Children on a guaranteed issue basis during a specified enrolment period following completion of any required eligibility waiting period.

Special Offer (when applicable) means Voluntary Group Critical Illness Insurance and Dependent Child Critical Illness Insurance available to eligible Employees, their Spouse and/or Dependent Children on a guaranteed issue basis during a specified open enrolment period.

Specialist means a licensed medical practitioner who

- has been trained in the specific area of medicine relevant to the Covered Condition or AdvanceCare Benefit Condition for which a benefit is being claimed;
- has been certified by a specialty examining board; and
- is currently practicing in their area of specialty in Canada or the United States of America.

Specialist includes but is not limited to: cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The Specialist and any medical professional performing any tests or examinations required to satisfy the Covered Condition requirements must not be the Insured Person, a relative or business associate of the Insured Person.

In the absence or unavailability of a Specialist, and as approved by the Company, a Covered Condition or AdvanceCare Benefit Condition may be diagnosed by a qualified medical practitioner practicing in Canada or the United States of America.

Spouse means your legal or common-law spouse. Legal spouse is a person who is legally married and cohabiting with you and with whom there is no formal or informal agreement of separation. Common-law spouse is a person who has been cohabiting in a marriage-like relationship with you for a period of not less than twelve consecutive months.

DEFINITIONS OF COVERED CONDITIONS – ALL INSURED PERSONS

Aortic Surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The Surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this condition for

- *Angioplasty;*
- *Intra-arterial procedures;*
- *Percutaneous trans-catheter procedures; or*
- *Non-surgical procedures.*

Aplastic Anemia means a definite Diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- Marrow stimulating agents;
- Immunosuppressive agents; or
- Bone marrow transplantation.

The Diagnosis of Aplastic Anemia must be made by a Specialist.

Bacterial Meningitis means a definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing the presence of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The Bacterial Meningitis must result in objective neurological deficits persisting for at least 90 days from the Date of Diagnosis.

The Diagnosis of Bacterial Meningitis must be made by a Specialist.

For purposes of the Group Policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable under this condition for viral meningitis.

Benign Brain Tumour means a definite Diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause Irreversible objective neurological deficit(s).

These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the neurological deficits.

The Diagnosis of Benign Brain Tumour must be made by a Specialist.

For purposes of the Group Policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions: No benefit will be payable under this condition for:

- *Pituitary adenomas less than 10 mm;*
- *Vascular malformations;*
- *Cholesteatomas; or*
- *Infectious or inflammatory tumours.*

90-Day Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the Issue Date of an Insured Person's coverage, or the last reinstatement date of an Insured Person's coverage, such Insured Person has any of the following:

- *Signs, symptoms, or investigations that lead to a Diagnosis of Benign Brain Tumour (covered or excluded under the Group Policy), regardless of when the Diagnosis is made; or*
- *A Diagnosis of Benign Brain Tumour (covered or not covered under the Group Policy).*

Medical Information about the Diagnosis and any signs, symptoms, or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Benign Brain Tumour or any critical illness caused by any Benign Brain Tumour or its treatment.

Blindness means a definite Diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

- the corrected visual acuity being 20/200 or less in both eyes; or
- the field of vision being less than 20 degrees in both eyes.

The Diagnosis of Blindness must be made by a Specialist.

Cancer means the definite Diagnosis of a malignant tumour. This tumour must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

The Diagnosis of Cancer must be made by a Specialist and must be confirmed by a pathology report.

For purposes of the Group Policy:

- T1a or T1b prostate cancer means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.
- The term gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1 means:
  - Gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm2, or 50 per HPF; or
  - Small intestinal, esophageal, colorectal, mesenteric and peritoneal GISTs that are less than or equal to 5 cm in greatest dimension with 5 or fewer mitoses per 5 mm2, or 50 per HPF;
- The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 1 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.
- The term Rai stage 0 is as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219,1975.

Exclusions: No benefit will be payable under this Covered Condition for the following:

- *Lesions described as benign, non-invasive, pre-malignant, of low and/or uncertain malignant potential, borderline, carcinoma in situ, or tumors classified as Tis or Ta;*
- *Malignant melanoma of skin that is less than or equal to 1.0mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;*
- *Any non-melanoma skin cancer, without lymph node or distant metastasis. This includes but is not limited to, cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;*
- *Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;*
- *Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0cm in greatest dimension and classified as T1, without lymph node or distant metastasis;*
- *Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;*
- *Gastro-intestinal stromal tumours classified as AJCC Stage 1;*
- *Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormonal oversecretion by the tumour; or*
- *Thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.*

90-Day Exclusion : No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the Issue Date of an Insured Person's coverage, or the last reinstatement date of an Insured Person's coverage, the Insured Person has any of the following:

- *Signs, symptoms or investigations leading directly or indirectly to a diagnosis of any cancer (covered or not covered under the Group Policy), regardless of when the diagnosis is made; or*
- *A diagnosis of any cancer (covered or not covered under the Group Policy).*

Medical Information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Cancer or any critical illness caused by any cancer or its treatment.

Coma means a definite Diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours and for which period the Glasgow coma score must be 4 or less. The Diagnosis of Coma must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for:

- *A medically induced coma; or,*
- *A coma which results directly from alcohol or drug use; or,*
- *A diagnosis of brain death.*

Coronary Artery Bypass Surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The Surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for:

- *Angioplasty;*
- *Intra-arterial procedures;*
- *Percutaneous trans-catheter procedures; or,*
- *Non-surgical procedures.*

Deafness means a definite Diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

The Diagnosis of Deafness must be made by a Specialist.

Heart Attack (acute myocardial infarction) means a definite Diagnosis of the death of heart muscle due to obstruction of blood flow that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

- Heart attack symptoms;
- New electrocardiogram (ECG) changes consistent with a heart attack;
- Development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The Diagnosis of Heart Attack must be made by a Specialist.

Exclusions: No benefit will be payable under this condition for:

- *ECG changes suggestive of a prior myocardial infarction;*
- *Other acute coronary syndromes, including angina pectoris and unstable angina; or*
- *Elevated cardiac biomarkers and/or symptoms that are due to medical procedures or diagnoses other than heart attack.*

Heart Valve Replacement or Repair means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for

- *Angioplasty;*
- *Inter-arterial procedures;*
- *Percutaneous trans-catheter procedures; or*
- *Non-surgical procedures.*

Kidney Failure means a definite Diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

The Diagnosis of Kidney Failure must be made by a Specialist.

Loss of Limbs means a definite Diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

The Diagnosis of Loss of Limbs must be made by a Specialist.

Loss of Speech means a definite Diagnosis of the total and irreversible loss of the ability to speak as a result of physical injury or disease, for a period of at least 180 days.

The Diagnosis of Loss of Speech must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for all psychiatric related causes.

Major Organ Failure on Waiting List means a definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the Insured Person must become enrolled as the recipient in a recognized transplant center in Canada or the United States of America that performs the required form of transplant surgery. For the purpose of the survival period, the Date of Diagnosis is the date of the Insured Person's enrolment in the transplant centre. The Diagnosis of the major organ failure must be made by a Specialist.

Major Organ Transplant means a definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

The Diagnosis of the major organ failure must be made by a Specialist.

Motor Neuron Disease means a definite Diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions.

The Diagnosis of Motor Neuron Disease must be made by a Specialist.

Multiple Sclerosis means a definite Diagnosis of at least one of the following:

- Two or more separate clinical attacks, confirmed by a magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- A single attack, with objective neurological deficits lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or,
- A single attack, confirmed by repeated MRI of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

The Diagnosis of Multiple Sclerosis must be made by a Specialist.

For purposes of the Group Policy, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable for the following:

- *Solitary sclerosis;*
- *Clinically isolated syndrome;*
- *Radiologically isolated syndrome;*
- *Neuromyelitis optica spectrum disorders; or*
- *Suspected multiple sclerosis or probable multiple sclerosis.*

1-Year Exclusion: No benefit will be payable under this Covered Condition if, within the first year following the later of the Issue Date of an Insured Person's coverage or the last reinstatement date of an Insured Person's coverage, the Insured Person has any of the following:

- *Signs, symptoms or investigations leading directly or indirectly to a diagnosis of multiple sclerosis (covered or not covered under the Group Policy) regardless of when the diagnosis is made; or*
- *A diagnosis of multiple sclerosis (covered or not covered under the Group Policy).*

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Multiple Sclerosis or, any critical illness caused by multiple sclerosis or its treatment.

Occupational HIV Infection means a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the effective date of such Insured Person's insurance coverage.

Payment under this condition requires satisfaction of all of the following:

- The accidental injury must be reported to the Company within 14 days of the accidental injury;
- A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
- A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America;
- The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

The Diagnosis of Occupational HIV Infection must be made by a Specialist.

Exclusion: No benefit will be payable under this condition if:

- *the Insured Person has elected not to take any available licensed vaccine offering protection against HIV;*
- *a licensed cure for HIV infection has become available prior to the accidental injury; or,*
- *HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.*

Paralysis means a definite Diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

The Diagnosis of Paralysis must be made by a Specialist.

Severe Burns means a definite Diagnosis of third-degree burns over at least 20% of the body surface.

The Diagnosis of Severe Burns must be made by a Specialist.

Stroke (cerebrovascular accident resulting in persistent neurological deficits) means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis, haemorrhage, or embolism with:

- Acute onset of new neurological symptoms, and
- New objective neurological deficits on clinical examination;

persisting for more than 30 days following the Date of Diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing showing changes that are consistent in character, location and timing with the new neurological deficits.

The Diagnosis of Stroke must be made by a Specialist.

For purposes of the Group Policy, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable under this covered condition for:

- *Transient Ischaemic Attacks;*
- *Intracerebral vascular events due to trauma;*
- *Ischaemic disorders of the vestibular syndrome;*
- *Death of tissue of the optic nerve or retina without total loss of vision of that eye; or*
- *Lacunar infarcts which do not meet the definition of stroke as described above.*

DEFINITIONS OF COVERED CONDITIONS – EMPLOYEES AND SPOUSES ONLY

Dementia, including Alzheimer's Disease means a definite Diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- Aphasia (a disorder of speech);
- Apraxia (difficulty performing familiar tasks);
- Agnosia (difficulty recognizing objects); or
- Disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behavior), which is affecting daily life.

The Insured Person must exhibit:

- Dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- Evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6-month period.

The Diagnosis of Dementia, including Alzheimer's Disease must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for affective or schizophrenic disorders, or delirium.

For purposes of the Group Policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189.

Loss of Independent Existence means a definite Diagnosis of the total inability, due to disease or injury, to perform independently, with or without the aid of assistive devices, at least 3 of 6 Activities of Daily Living listed below for a continuous period of at least 90 days with no reasonable chance of recovery. The Diagnosis must be made by a physician and supported by an independent home care assessment made by an occupational therapist or equivalent.

Activities of Daily Living are as follows:

Bathing: washing oneself in a bathtub, shower or by sponge bath;

Dressing: putting on and removing necessary clothing, braces, artificial limbs or other surgical appliances;

Toileting: getting on and off the toilet and maintaining personal hygiene;

Bladder and bowel continence: managing one's bladder and bowel function with or without protective undergarments or surgical appliances so that hygiene is maintained;

Transferring: moving in and out of a bed, chair or wheelchair;

Feeding: consuming food or drink that already has been prepared and made available.

No additional survival period is required once the conditions described above are satisfied.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders means a definite Diagnosis of primary Parkinson's Disease, a permanent neurological condition which must be characterized by bradykinesia (slowness of movement) and at least one of the following: muscular rigidity or rest tremor. The Insured Person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease. Specified Atypical Parkinsonian Disorders are defined as a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The Diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a Specialist.

1-Year Exclusion: No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the later of the Issue Date or the latest reinstatement date of an Insured Person's coverage, such Insured Person has any of the following:

- *Signs, symptoms or investigations that lead to a Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the Diagnosis is made; or*
- *A Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.*

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

No benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of parkinsonism.

DEFINITIONS OF ADVANCECARE BENEFIT CONDITIONS – EMPLOYEES AND SPOUSES ONLY

Coronary Angioplasty means the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a Specialist.

Early Stage Cancer refers to one of the following conditions:

- Malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;
- Gastrointestinal stromal tumours classified as AJCC Stage 1;
- Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormone oversecretion by the tumour;
- Thymomas (Stage 1), confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus; or
- Ductal Carcinoma in situ of the Breast.

The Diagnosis of an Early Stage Cancer must be made by a Specialist.

DEFINITIONS OF COVERED CONDITIONS – DEPENDENT CHILDREN ONLY

Cerebral Palsy means a non-progressive neurological defect characterized by spasticity and incoordination of movements.

Congenital Heart Disease means a Diagnosis of one of the following heart conditions following a 30-day survival period from Diagnosis or birth, whichever comes later. The Diagnosis must be made by a qualified pediatric cardiologist and supported by appropriate cardiac imaging.

- Atresia of any heart valve
- Coarctation of the Aorta
- Double Inlet Ventricle
- Double Outlet Left Ventricle
- Ebstein's Anomaly
- Eisenmenger Syndrome
- Hypoplastic Left Heart Syndrome
- Hypoplastic Right Ventricle
- Single Ventricle
- Tetralogy of Fallot
- Total Anomalous Pulmonary Venous Connection
- Transposition of the Great Vessels
- Truncus Arteriosus

Exclusion: Trans-catheter procedures such as balloon valvuloplasty or percutaneous Atrial Septal Defect closure are excluded. All other congenital cardiac conditions are excluded.

Cystic Fibrosis means a definitive Diagnosis of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency.

Down Syndrome means a definitive Diagnosis of Down Syndrome supported by chromosomal evidence of Trisomy 21.

Muscular Dystrophy means a definitive Diagnosis of Muscular Dystrophy, characterized by well defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

Type 1 Diabetes means a Diagnosis of type 1 diabetes, characterized by absolute insulin deficiency and continuous dependence on exogenous insulin for survival. The Diagnosis must be made by a qualified pediatrician or endocrinologist licenced and practicing in Canada or the United States of America and there must be evidence of dependence on insulin for a minimum of three months.

CLAIMS AT TUGO

As an insured person under a Company critical illness insurance plan, you are eligible to access **Claims at** TuGo. **Claims at** TuGo is a service that provides assistance in obtaining specialized, private medical treatment at claim time. **Claims at** TuGo coordinates medical appointments and procedures with specialists and surgeons at special pricing discounts.

For assistance in accessing this service, please visit www.tugo.com/tms.

Note that utilization fees may apply.

GENERAL PROVISIONS

Termination of Insurance in Respect of an Insured Person

An Insured Employee's insurance will terminate automatically on the earliest of the following dates:

a) the termination date of the Group Policy;
b) the date of death of the Insured Employee;
c) the end of the month coincident with or following the date on which the Employee's employment terminates or changes so that the Employee ceases to be eligible for insurance under the Group Policy;
d) the date an Employee, under age 65 and residing in Québec, is no longer covered under a private drug plan provided by the Policyholder, as required by the Québec Act respecting prescription drug insurance;
e) the end of the policy year coincident with or following an Employee's 75th birthday;
f) the due date of any unpaid premiums;
g) the end of the month coincident with or following the date that the Company receives written notice from the Employee requesting cancellation of all or part of the insurance; and
h) the end of the month coincident with or following the date on which a leave of absence has expired and the Employee is not actively at work.

An Insured Spouse's Insurance will terminate automatically on the earliest of the following dates:

a) the termination date of the Group Policy;
b) the date of death of the Employee or Insured Spouse;
c) the end of the month coincident with or following the date on which the Employee's employment terminates or changes so that the Employee ceases to be eligible for insurance under the Group Policy;
d) the end of the policy year coincident with or following a Spouse's 75th birthday;
e) the due date of any unpaid premiums;
f) the end of the month coincident with or following the date the Company receives written notice from the Employee requesting cancellation of all or part of the Spouse's insurance;
g) the end of the month coincident with or following the date on which a leave of absence has expired and the Employee is not actively at work; and
h) the end of the month coincident with or following the date on which they no longer qualify as a Spouse.

The Dependent Child Critical Illness Insurance in respect of an Insured Dependent Child will terminate automatically on the earliest of the following dates:

a) the termination date of the Group Policy;
b) the date that the Dependent Child Covered Condition Benefit is paid with respect to that Insured Dependent Child;
c) the date of death of the Insured Employee or Insured Dependent Child;
d) the date all of the Insured Employee's Voluntary Group Critical Illness Insurance terminates;
e) the end of the month coincident with or following the date on which the Employee's employment terminates or changes so that the Employee ceases to be eligible for Dependent Child Critical Illness Insurance under the Group Policy;
f) the end of the policy year coincident with or following an Employee's 75th birthday;
g) the due date of any unpaid premiums;
h) the end of the month coincident with or following the date the Company receives written notice from the Employee requesting cancellation of the Dependent Child Critical Illness Insurance coverage; and
i) the end of the month coincident with or following the date on which a leave of absence has expired and the Employee is not actively at work; and
j) the end of the month coincident with or following the date on which an Insured Dependent Child no longer qualifies as a Dependent Child.

Important note regarding termination of your coverage:

You must advise our office in writing once you, your Insured Spouse, and/or your Insured Dependent Child(ren) are no longer eligible for coverage under the Group Policy, if applicable.

Depending on when the Company is advised, the premium payor may be eligible to receive a premium refund of up to 3 months, if applicable.

CLAIMS PROCEDURES

Before paying a benefit under the Group Policy, we will require our claims forms to be duly completed and sent to the Company's address below. Please call us toll-free at: 1.800.266.5667 to obtain the appropriate forms and for details on claims procedures.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act. Insurance Act means the applicable insurance legislation in the applicable provincial jurisdiction.

Note: All claims will be adjudicated according to the definition of the Covered Condition or the AdvanceCare Benefit Condition applicable at the time of Diagnosis.

QUESTIONS? WE'RE HERE TO HELP.

Contact a Client Service Specialist at:

1.800.266.5667 (toll free)
604.737.3802 (Vancouver)
SpecialMarkets@ia.ca
Monday to Friday 6:30 a.m. - 4:30 p.m. Pacific Time

Or write to:

iA Special Markets
Industrial Alliance Insurance and Financial Services Inc.
400 - 988 W Broadway PO Box 5900
Vancouver, BC V6B 5H6

Or visit our website at:

www.ia.ca

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